DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

March 6, 2007

Dear Tribal Leader:

I am pleased to provide you with a copy of the U.S. Department of Health and Human Services 2006 Tribal Consultation Report. This is a collective effort by our Department to highlight our progress and achievement with tribal issues and activities. Our partnership with Tribes is the very foundation for our consultations and we are committed to working with Tribes on a government-to-government basis.

Some of our key collective accomplishments include the creation of the American Indian/Alaska Native Health Research Advisory Council, the creation of the Centers for Disease Control Tribal Technical Advisory Council and the distribution of funding dedicated to combating Methamphetamine Abuse in Indian Country. We also had two successful trips to Alaska with Deputy Secretary Azar visiting Indian Country and hosted a pandemic flu summit at HHS headquarters for Tribal leaders and representatives nationwide.

We anticipate continued dialogue at our annual regional consultations that are being held across the nation in the spring. An invitation to participate in these meeting's will be forthcoming from your Regional Director. These sessions provide the opportunity to review of our activities, accomplishments, and discussion of emerging issues. I hope that you will be able to join us.

I want to introduce two new staff members in the Office of Intergovernmental Affairs (IGA). Stacey Ecoffey is our Principal Advisor for Tribal Affairs. She serves as the principal advisor on tribal issues and the implementation of the HHS consultation policy. She is also the primary point of contact for Tribes. Stacey is an enrolled member of the Oglala Sioux Tribe from Pine Ridge, South Dakota. Kimberly Romine joins us as the Executive Director for the Intra-Departmental Council on Native American Affairs. Kim's primary responsibility is to coordinate our Department's activities and initiatives for American Indians/Native Americans/Alaska Natives. Kim is an enrolled member of the Seneca Nation of New York.

I would like to invite you to participate in our 9th Annual Department Wide Tribal Budget Consultation Session, which will be held on March 28-29, 2007 in Washington, DC. IGA staff will be coordinating development of the agenda with Tribal leaders and Tribal organizations. I continue to invite you and your staff to participate in planning this process. If you would like to participate, you may contact us at (202) 690-6060.

I value your participation in our meetings and our continued partnership.

Sincerely,

Jack Kalavritinos
Director, Intergovernmental Affairs

Department of Health and Human Services

2006
Tribal Consultation Report

Prepared by:
The Office of Intergovernmental Affairs
March 1, 2007

ACKNOWLEDGEMENTS

The 2006 Tribal Consultation Report is a collective effort by our Department to highlight our progress and achievement with tribal issues and activities. Our partnership with Tribes is the very foundation for which consultation stems and Secretary Leavitt remains committed to working with Tribes on a government-to-government basis.

Some of our key collective accomplishments have occurred as a result of discussion during the Regional Tribal Consultation Sessions. As a result of last year's consultations and learning of rising concern about methamphetamine abuse in Indian Country, HHS committed $1.2 million to Indian Country to assist in that fight against this deadly drug. HHS also committed to partnering with the Tribes on the creation of the American Indian/Alaska Native Health Research Advisory Council. This Advisory Council is designed to work in consultation with 6 of our agencies to assist in developing the best ways for us to coordinate and communicate our research activities with Indian Country.

Many individuals work behind the scenes to support Tribal Governments and Native American communities. In addition to the activities of our senior leadership, it is the HHS Tribal Liaisons who help Tribes navigate through our Department and move forward our goals with their Divisions. An updated contact list is included in this report for your reference and we encourage you to contact them for assistance.

I also wish to express my gratitude to Stacey Ecoffey, Kim Romine and Jeremy Marshall who provided significant assistance in collecting, compiling, writing, and editing the information in this report.

Please feel free to review this report online at our office's website: http://www.hhs.gov/ofta.

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Executive Summary

This is the sixth annual consultation report developed by the U.S. Department of Health and Human Services (HHS) in compliance with the HHS Tribal Consultation policy. It provides an overview of the array of Tribal consultation activities conducted by HHS programs during fiscal year 2006 and includes issued raised by the Tribes, as well as the progress made within HHS to address those issues.

In his Native American Heritage Month Proclamation on October 30, 2006, President Bush reaffirmed tribal sovereignty and the right of American Indian and Alaska Native Tribes to self-determination as well as ensuring open access to all opportunities.

> *"America is blessed by the character and strength of American Indians and Alaska Natives and our citizens are grateful for the countless ways Native Americans have enriched our country and lifted the spirit of our Nation..... My Administration will continue to work on a government-to-government basis with tribal governments, honor the principles of tribal sovereignty and the right to self-determination, and help ensure America remains a land of promise for American Indians, Alaska Natives, and all our citizens."*

One of the fundamental signs of respect for Tribal sovereignty referred to by the President in the quote above is the continuation to work with tribal governments on a government-to-government basis through consultation. HHS has an extensive history of promoting and conducting such consultation. This report chronicles the many Tribal consultation activities that have been conducted across HHS in 2006.

In 2006, Tribal consultation at HHS took many forms. National division and budget consultations that focused on the health and human services tribal priorities for programs and budget dollars, regional consultation sessions coordinated by HHS regional directors, and HHS Division sponsored consultation all served to provide Tribes multiple opportunities for Tribes to make their views and priorities known to HHS officials on a wide variety of health and human services issues. HHS senior staff continued to travel throughout Indian Country. This travel has been at the invitation of Tribal leaders who have repeatedly stated that there is no substitute for seeing health and human service conditions first hand in Indian communities.

This report catalogs these and other forms of consultation undertaken over the past year.

Section 1: Tribal Priorities discusses the various Tribal priorities shared through HHS, division and regional consultation efforts, including: access to health services; behavioral health, data and research; eliminating health disparities; emergency preparedness/homeland security; funding and budget issues; health promotion and disease prevention; increased access to HHS resources; legislation; Medicaid; Medicare Modernization Act and Tribal consultation and intergovernmental relations.

Section 2: Overview of Consultation Activities lists the consultation efforts that have been undertaken by HHS Divisions and Regional Offices and others during the last year. In addition to the nine regional Tribal consultations, the first HHS National Division Consultation Session and the HHS Annual Tribal Budget Consultation Session, many other regions and divisions consulted with Tribes on specific issues. In order to distinguish national from local or regional consultation efforts, this section is organized according to type of consultation, including: regional Tribal consultations; HHS Annual Tribal Budget Consultation Session; HHS leadership visits to Indian Country; Intradepartmental Council on Native American Affairs (ICNAA); workgroups and task forces; Tribal delegation meetings; region-and division-specific consultation; and Tribal conferences and summits. Information about the date(s),

sponsoring division or region, membership or attendees, and a brief summary are included in each consultation activity.

Section 3: Outcomes and Accomplishments connect Sections 1 and 2. Outcomes on the Tribal priorities achieved through Tribal consultation are included in this section. Major HHS responses to Tribal priorities, as well as region and division outcomes and accomplishments, are provided in this section.

The major HHS outcomes and accomplishments for fiscal year 2006 included:

- National Tribal Leaders Pandemic Influenza Preparedness Summit
- Meth Abuse in Indian Country: Roundtable Sessions
- American Indian/Alaska Native Health Research Advisory Council Meeting
- Regional Tribal Consultation Sessions
- 1st Annual National Divisional Tribal Budget Consultation Session
- 8th Annual National HHS Tribal Budget Consultation Session
- Improved Tribal Access to HHS Resources

Section 4: Tribal Assessments of Consultation Efforts provide a summary of Tribal feedback on the Annual Tribal Budget Consultation Session and Regional Tribal Consultation Sessions.

Finally, the expanded **Appendices** section offers a wealth of supportive information to maximize this report's use as a resource. The Office of Intergovernmental Affairs and Regional Office staff lists; ICNAA members and liaison roster; two tables reflecting HHS Funding for tribes; HHS Tribal Consultation policy; HHS organizational chart, Indian Health Service Areas map; acronym descriptions; and a comprehensive index are all part of the Appendices section.

Section 1
Tribal Priorities

Section 1: Tribal Priorities

CONSULTATION SESSIONS TRIBAL PRIORITIES

During the course of the Regional Consultation Sessions and the HHS Annual Tribal Consultation Session, Tribes raised a number of specific budget, policy, legislative and regulatory and other concerns. The list below aggregates these issues into broad categories. This list remains very similar to the list included in the 2005 HHS Tribal Consultation Report.

Access to Health Services
Behavioral Health
Data and Research
Eliminating Health Disparities
Emergency Preparedness/Homeland Security
Funding and Budget Issues
Health Promotion and Disease Prevention
Increased access to HHS resources
Legislation
Medicaid
Medicare Modernization Act
Deficit Reduction Act
Tribal Consultation and Intergovernmental Relations

In addition to these broad, over-arching categories, Tribes mentioned a number of very specific concerns at many sessions. The list below includes a sample of issues that were raised frequently by the Tribes.

1. Increased funding
2. Indian Health Care Improvement Act reauthorization
3. TANF reauthorization and the need for more outreach on Tribal TANF
4. Increased awareness of Tribal needs and funding for emergency preparedness/homeland security
5. Increased flexibility by HHS when dealing with Tribes
6. Increased access to HHS programs for Tribes through elimination of barriers
7. Support passage of legislation authorizing self-governance outside IHS
8. Support Tribal consultation
9. Develop Tribal research capacity and strategy
10. Medicare and Medicaid issues
11. Tribal Head Start
12. Positive youth development and suicide prevention
13. Services for Indian Veterans
14. Aging issues, i.e., long-term care, improves services for the elderly
15. Methamphetamine use in Indian Country
16. Diabetes prevention and treatment
17. High cost of pharmaceuticals
18. Medicare Modernization Act implementation
19. Establish direct funding of HHS programs currently funded by state block grants to Tribes
20. State accountability for HHS funding received for services for Tribes
21. Increase resources for facility construction and sanitation facilities
22. Impact of the Deficit Reduction Act on Tribes
23. Requesting States work more with Tribes and include tribes in the distribution of funds
24. Urban Indian Health Issues

DIVISION TRIBAL PRIORITIES

This section of the report describes the objectives developed by various HHS programs to address the Tribal priorities identified in 2005.

Administration for Children and Families (ACF)

Child Care Bureau (CCB)

PRIORITY

Objective: Increase opportunities for research on tribal child care issues.

Background: The 2003 ACF Tribal Consultation presenter stated that "*The Child Care Bureau has been appropriated 10 million dollars for research and evaluation since 2000. Little information is known or available which is pertinent to the tribal child care community. Specific research funds must be set aside to gather data, and research the effectiveness of early childhood practices in the tribal community if we are to improve the quality of care for Indian children."*

While priorities vary from year to year, CCB typically issues an annual announcement seeking applications for research grants. Tribes or Tribal organizations may partner with an eligible research entity to apply for funding under CCB's research announcement. CCB has supported research that is relevant to Tribal communities and has disseminated research findings to Tribal grantees to inform them of their administration of child care programs.

Activities:

Activity 1: CCB provided funds for the Families and Work Institute (FWI) to publish and disseminate FWI's Phase II report on the *Sparking Connections* sites. The report, released in September 2006, summarizes lessons learned and recommendations from multi-site evaluations of community-based strategies to support family, friend, and neighbor caregivers of children. One of the sites, the Oklahoma Child Care Resource and Referral Association, Inc., was funded by CCB in FY2004 and FY2005 to focus on family, friend, and neighbor care initiatives with four Oklahoma Tribes. Dissemination of the final report should promote replication opportunities for other Tribes. The report is available at: http://familiesandwork.org/eproducts/sparking-phase2.pdf.

Activity 2: CCB is funding a three-year market-rate survey research study with Oregon State University (partnering with the University of Minnesota and Columbia University's National Center for Children in Poverty) to examine how well market-rate surveys assess the price of care in various types of communities, what methods validate market-rate survey findings, and the effects of child care subsidies on the larger child care market. In the project's second year, States, Territories, and Tribes were surveyed to assess current market-rate survey practices and issues. FY2006 funding: $206,453.

Activity 3: CCB is funding a two-year research scholar grant study titled "The Role of Tribal Child Care Programs in Serving Children Birth to Five" to investigate American Indian child care directors' perceptions of the Reservation community's efforts to promote and preserve cultural integrity in the local transmission of cultural values to children aged birth to five who are enrolled in Tribal child care programs on Indian Reservations. In addition, the study will address the directors' perceptions of how Statewide quality improvement systems are (or are not) assisting the directors in their efforts to promote continuity of cultural education and quality child care. Interviews with Tribal administrators were conducted in summer 2006. FY2006 funding: $20,000.

Expected Outcomes: Overall, the above activities are beginning to fill gaps in Tribal child care research. Specifically, these projects will accomplish the following:

- Through parent education and support, partnerships, and other supportive

activities, the quality of child care provided by informal providers will be enhanced.

- The market-rate survey study will inform policy and program choices about the impact of child care subsidies on child care prices, about the ways child care assistance impacts other families needing child care, and about strategies for forecasting program expenditures.

- An assessment will be made as to how Tribes are promoting and preserving cultural integrity in the transmission of values in Tribal child care programs and, as to how Statewide quality improvement systems are assisting Tribal child care programs in their efforts to promote continuity of cultural education, values, and quality child care.

Divisions and Other Groups Involved in Addressing Priority:

Cherokee Nation (coordinating on behalf of Choctaw Nation, Eastern Shawnee Tribe, and the United Keetoowah Band as participants in Sparking Connections);
Child Care Bureau (CCB)/Office of Family Assistance (OFA)/Administration for Children and Families (ACF)/Department of Health and Human Services (DHHS);
Oklahoma Child Care Resource and Referral Association;
Oregon State University;
University of Nebraska; Tribal Child Care Directors (part of a University of Nebraska study).

Objective: Build or enhance school-readiness capacity in tribal communities.

Background: Both States and Tribes are required by Federal statute and Child Care and Development Fund (CCDF) regulations to describe within their CCDF two-year plans how they are coordinating with each other to provide child care services within their boundaries. Since 2002, the President's *Good Start, Grow Smart (GSGS)* Early Learning Initiative has been a catalyst for increased State-Tribal coordination and collaboration around the development and implementation of early learning guidelines, the establishment of statewide professional development systems, and the coordination of various Federal and State early care and education programs and funding streams. CCB has provided technical assistance to Tribes on various aspects of the President's *GSGS* initiative, including early literacy and language acquisition, at the National Tribal Child Care Conference, at ACF Regional Tribal Conferences, and at Tribal Cluster Trainings.

Activities:

Activity 1: In August 2006, CCB brought its Tribal Child Care grantees together with their State counterparts at a national conference titled *Diverse Perspectives—Common Goals*. This was the first time in more than a decade that CCB had brought together both the Tribal and the State grantees that are the recipients of the block grant funds to subsidize child care for low-income working families. The conference included facilitated State-Tribal discussion sessions that allowed each State to meet with the Tribal programs located in the respective State to discuss coordination of services, including provider training and implementation of early learning guidelines under *GSGS*. A number of States and Tribes identified specific follow-up steps to improve communication, including adding Tribes to State contact lists for disseminating announcements and mailings. In addition, the conference included numerous workshops and plenary sessions on other *GSGS*-related topics, including professional development of child care providers, school readiness and school success, and collaboration with Head Start and Temporary Assistance for Needy Families (TANF) programs.

Activity 2: In April 2006, through its Tribal Child Care Technical Assistance Center (TriTAC), CCB sponsored a Native Leadership Forum on Cultural Curricula and Indigenous Language Acquisition in Child Care in Honolulu, Hawaii. Tribal Child Care grantees (including the Bureau's Native Hawaiian grantee) joined representatives from US

Territories, Native language immersion charter schools (one Hawaiian and one Ojibwe), universities, and a Hawaiian Head Start/Early Head Start grantee. Participants learned about strategies to develop and implement Native culture and language programs for young children in various child care settings. Forum participants toured a co-located pre-school and public charter school, which offered participants an opportunity to see children successfully learning in a full Hawaiian-language immersion environment. Participants were greeted by the children and staff of both schools in a traditional ceremony welcoming them as visitors and new members of the campus's "'Ohana" (family).

Expected Outcomes: Tribes can influence State policy by bringing important cultural and Native language considerations to the attention of State policymakers, as they work with States on the development or enhancement of State early learning guidelines. Tribes will have access to a broader network of professional development resources and training within their States.

By accessing State training activities, Tribal child care programs will have the opportunity to build their capacity to provide quality care, while at the same time increasing their ability to serve more families because the funds previously spent on professional development activities can be diverted to direct services. Tribal child care programs will increase opportunities for children in child care settings to build or enhance their acquisition of Native language and culture, which improves school readiness.

Divisions and Other Groups Involved in Addressing Priority: Child Care Bureau (CCB)/Office of Family Assistance (OFA)/Administration for Children and Families (ACF) /Department of Health and Human Services (DHHS); Tribal Child Care Technical Assistance Center.

Office of Community Services (OCS):

PRIORITY

Objective: OCS programs promote the goals of ameliorating the causes and conditions of poverty and self-sufficiency for low-income persons through the provision of assistance for home energy costs, housing, employment, health, and transportation.

Background: The priority is derived from OCS' mission.

Activities:

Activity 1: Community Services Block Grant (CSBG) division provides training and technical assistance for Tribal grantees' programs.

Activity 2: Division of Energy Assistance held the National Low-Income Energy Consortium in Washington, D.C., at which OCS staff met with Tribal representatives to discuss the Tribes' programs and funding.

Expected Outcomes: To produce trained persons within the scope of Low Income Home Energy Assistance Program (LIHEAP) and CSBG programs to Tribal grantees.

Divisions and Other Groups Involved in Addressing Priority: N/A

Agency for Healthcare Research and Quality (AHRQ)

PRIORITY:

Objective: To increase access to HHS resources.

Background: This objective is consistent with the Department's emphasis that all operating and staff divisions, not just IHS and ANA, look for ways to support tribes and tribal organizations.

Activities: AHRQ will continue efforts to become better known throughout Indian country, make its funding opportunities better known, and try to generate more grant applications from tribes and multi- tribal organizations. AHRQ has been sending notices of grant announcements to IHS, the IHS director of the Native American Research Centers for Health

program, the Native Research Network, and others for posting on their respective websites, list serves, etc.

AHRQ has been very active in the implementation of the new HHS Tribal Advisory Council on Health Research. This Council includes numerous other HHS organizational units including NIH, CDC, IHS, and the Office of the Assistant Secretary for Planning and Evaluation, the Office of Minority Health, and the Office of Intergovernmental Affairs. The purposes of the Council are to: obtain input from tribal leaders on health research priorities and needs for their communities; provide a forum through which OPDIV and STAFFDIV representatives can better communicate and coordinate the work their respective organizations are doing in AI/AN health research; and provide a conduit for disseminating information to tribes about research findings from studies focusing on the health of AI/AN populations. The Council is another conduit through which AHRQ can become better known throughout Indian country.

Expected outcomes: We hope to receive and, ultimately, fund more grant applications from tribes and multi-tribal organizations.

Divisions And Other Groups Involved In Addressing Priority: All other HHS components.

PRIORITY:

Objective: Improve the data and expand the research results available to tribes to direct their future activities.

Background: This is a theme heard at the last several departmental budget consultation sessions.

Activities: AHRQ is closely involved in the work being done by the newly formed HHS Tribal Advisory Council on Health Research. It is hoped that this group will help to better identify tribal health research needs and priorities for the Department and serve to help transmit research results back to tribes and multi-tribal organizations.

AHRQ is funding several research projects to develop more information to help tribes and tribal organizations identify best practices. AHRQ is funding and is working closely with IHS in the development of an electronic health record that will be used in IHS and can be used in tribal programs. Among the many purposes of EHRs, they can be used to generate important data on utilization that can be used for research purposes.

Expected Outcomes: Increase the volume and quality of research results available to tribes and IHS to help guide them in designing their health care programs.

Divisions And Other Groups Involved In Addressing Priority: Many other departmental components are involved in activities to accomplish this objective.

PRIORITY:

Objective: Eliminate Health Disparities

Background: This is a Department-wide priority.

Activities: AHRQ supports a great many research and research-related activities aimed at developing and implementing research results that will lead to decreasing the extent of health disparities among priority populations. Some are AI/AN specific, others specific to minority populations, low income populations, rural populations, etc.

AHRQ develops the National Healthcare Disparities Report annually, as required by Congress.

The report presents the latest available findings on quality of and access to health care in the general U.S. population and among priority populations. It focuses on four components of quality—effectiveness, patient safety, timeliness, and patient centeredness—and two

components of access—facilitators and barriers to health care and health care utilization.

Expected Outcomes: Enable policy makers and others to make more informed decisions regarding what will work to decrease disparities among priority population groups and the overall population.

Divisions And Other Groups Involved In Addressing Priority: Most, if not all, of HHS components are involved in this objective.

***PRIORITY*:**

Objective: Develop tribal research capacity.

Background: In consultation sessions, tribal representatives have expressed an interest in nurturing tribes' own research capabilities.

Activities: AHRQ funds at least two large grants to tribes/tribal organizations which seek to build research capacity as well as fund specific research projects. The recipients are the Montana-Wyoming Tribal Leaders Council (funded under an AHRQ Minority Research Infrastructure Support Program grant) and the other, the California Rural Indian Health Board (funded as part of the NIH-IHS Native American Research Centers for Health [NARCH] program).

AHRQ makes efforts to apprise tribes and tribal organizations of its research capacity building grant programs (see Priority entitled ""To increase access to HHS resources"), in particular, the Minority Research Infrastructure Support Program (M-RISP) and, previously, the Building Research Infrastructure and Capacity Program (BRIC).

Expected outcomes: Improved understanding of and capacity for conducting research among tribes and tribal organizations.

Divisions and Other Groups Involved In Addressing Priority: IHS, NIH

Administration on Aging (AoA)

PRIORITY: Aging Issues – Long-term Care

Objective: Assist Tribes in planning for long-term care by providing a forum for Tribes to: 1) learn from each other about promising practices in sustainable programs of long term care; 2) learn about resources available to help in the development of long-term care services; and 3) learn from experts in the field about specific technical issues.

Background: Although this issue was raised at several HHS consultation sessions, AoA, IHS, CMS, and ANA have been working together on long-term care issues for several years.

Activities: AoA, IHS, CMS, ANA will facilitate an annual conference to discuss long-term care issues in Indian Country. The third annual conference is scheduled September 4-7, 2007 in Albuquerque, NM.

Expected Outcomes: Tribes will be more knowledgeable about long-term care programs and services. This will be measured by conducting a conference evaluation.

Divisions and Other Groups Involved In Addressing Priority: IHS, CMS, ANA, many Tribes and other organizations are involved in addressing this priority. Tribes represented on the planning committee include: Cherokee Nation, ANTHC, Isleta Pueblo, Eastern Band of Cherokee Indians, Jamestown S'Klallam Tribe, Muscogee Creek Nation, Navajo Nation, Blackfeet Nation, Sherwood Band of Pomo Indians, Tohono O'odham, Comanche Nation, and Pribilof Islands. Additionally, representatives from NICOA, AARP, the Minnesota Department of Human Services, and the University of North Dakota serve on the planning committee.

Assistant Secretary for Planning and Evaluation (ASPE)

PRIORITY: Increased Access to HHS Resources

Project 1:

Objective: To increase understanding of the programmatic and administrative barriers preventing American Indian, Alaska Native and Native American (AI/AN/NA) communities from more fully accessing those HHS grant programs for which they are eligible as well as strategies for improving access.

Background: Increased access to HHS programs by AI/AN/NAs is a priority of the ICNAA and the Tribes identified during FY 2006 regional Tribal consultation sessions. An ICNAA project using FY 2004 Tracking Accountability in Government Grants System (TAGGS) data indicated that for most of the HHS programs available to AI/AN/NA groups, very few are funding more than one or two tribal groups, and many are not reaching such organizations at all.

Activities: ASPE's Office of Human Services Policy and its partners including ASRT, ANA and ICNAA supported a study conducted from September 2004-April 2006 entitled: *Barriers to American Indian, Alaska Native and Native American Access to HHS Programs.* A Work Group that included Tribal representation provided feedback during all phases of the study. The immediate outcome was the gathering of information on perspectives of the programmatic and administrative barriers through a survey of 148 HHS personnel, 6 focus groups with HHS personnel, and discussions with 150 Tribal representatives attending 5 national conferences.

Expected Outcome: A final report that synthesizes the findings on barriers and solutions, discusses the similarities and differences in perspectives between HHS officials and Tribal representatives, and addresses practical considerations in implementing the suggested strategies has been completed and disseminated.

Divisions and Other Groups Involved in Addressing Priority: In addition to the funding partners (see above), a Working Group consisting of representatives from ACF/ANA, AoA, IGA, NIH, CDC, HRSA, SAMHSA, IHS, National Congress of American Indians, and the Tribal Self-Governance Advisory Committee met to advise the project staff and Westat, the contractor.

Project 2:

Objective: To establish a AI/AN Health Research Advisory Council within HHS.

Background: Many components of HHS support research on the health needs of AI/ANs, but these components have not had AI/AN groups to provide advice, nor has there been any organization within HHS that is charged with coordinating this research area. Having a single organization conduct consultations is more efficient than having individual Operating and Staff Divisions conduct their own health research consultations with AI/AN leaders and groups. The purposes of the Council are to: obtain input from Tribal leaders on health research priorities of AI/ANs, provide a forum for the Department to coordinate work on health research, and disseminate information to Tribes about research findings.

Activities: ASPE in partnership with IHS, AHRQ, CDC NIH, OMH, and IGA helped establish and provided staff and ongoing support for the Council. The Office of Minority Health chairs the Council. The immediate outcome was the first meeting of the Council held on May 18-19, 2006 in Washington D.C. Representatives from most of the IHS Area Regions attended as well as staff from AI/AN national organizations.

Expected Outcomes: Additional meetings of the Council will be held on a yearly basis, and an annual report will be disseminated to the Department and to all federally recognized Tribes.

Divisions and Other Groups Involved in Addressing Priority: In addition to representatives from the above agencies, Tribal representatives from each of the 12 IHS regions and five national AI/AN organizations are involved.

PRIORITY: Data and Research

Project 1:

Objective: To enhance knowledge of existing federal, state and other relevant health and human service related data sources pertaining to AI/AN/NAs as well as coverage gaps and possible remedies for these data gaps.

Background: High-quality, up-to-date data pertaining to AI/AN/NAs are critical to understanding the health and well-being of this population; identifying social, economic and health disparities; and studying changes over time. Ideally, AI/AN/NA data should include information on a large array of social and health indicators; however, the data currently available on AI/AN/NAs are severely limited.

Activities: ASPE's Office of Human Services Policy is supporting a study entitled *Data on the Health and Well-being of American Indians, Alaska Natives, and Native Americans* that will compile information on existing health and human services data sources pertaining to AI/AN/NAs, explore the quality and usefulness of these data, and identify ways to improve the usefulness, and coverage of the data. The study is being conducted from October 2005 to Winter 2007. The immediate outcome is the completion of a series of research tasks by Westat (contractor) that address the study's objectives.

Expected Outcomes: The products of this study will include a descriptive catalogue of existing data sources and an overview paper on data gaps and options for addressing them. Methods used to develop these products include an assessment of existing data sources, discussions with government and nongovernmental officials working on AI/AN/NA data issues, and a synthesis of this information to identify gaps and remedies.

Divisions/Other Groups Involved in Addressing Priority: In addition to ASPE and Westat staff (the contractor); members of the HHS Data Council and its Working Group on Race and Ethnicity, a Workgroup consisting of representatives of AI/AN/NA organizations, and officials of relevant HHS agencies are involved in this study.

Project 2:

Objective: To improve racial and ethnic data within the Department including data pertaining to AI/AN/NAs.

Background: The *HHS Data Council* was formed to provide a forum and advisory body to the Secretary on health and human services data policy and to coordinate data collection and analysis activities in HHS. The Council meets monthly and working groups meet periodically. The Council has established a *Working Group on Racial and Ethnic Data* to coordinate data activities and provide advice, technical assistance and staff support to the Council.

Activities: The ASPE co-chairs the *HHS Data Council* on a permanent basis along with the head of an Operating Division on a rotating basis. In addition, ASPE is a member of the *Working Group on Racial and Ethnic Data* described above. As one of its possible strategies for improving racial and ethnic data, the Working Group developed an HHS minority data website that can be found on the web at: http://www.hhs-stat.net/omh/index.htm

Expected Outcomes: The Working Group has suggested the following activities to improve racial and ethnic data including AI/AN/NA data: a coordinated analytical initiative to prepare special issue briefs on specific racial and ethnic minority populations, sponsorship of workshops, a project supported by National Center on Health Statistics and ASPE to examine methods for supporting a dual frame capability (i.e., use of two sampling methods in the same study; for example random digit dialing and numbers from a selected directory) on the National Health Interview Survey in order to expand coverage of racial and ethnic populations, and targeted expansion of data collection capability in major HHS surveys.

Divisions and Other Groups Involved in Addressing Priority*:* The Working Group on

Racial and Ethnic Data includes members from the HHS Operating and Staff Divisions and is co-chaired by the OMH and SAMHSA.

Project 3:

Objective: To provide advice and assistance to the Department regarding health data issues and serve as a forum for interaction with interested private sector groups on a variety of these issues.

Background: The National Committee on Vital and Health Statistics (NCVHS) serves as the statutory public advisory body to the Secretary of Health and Human Services in the area of health data and statistics and meets quarterly. The NCVHS is composed of 18 individuals from the private sector who are experts in a wide variety of fields. The Committee's Subcommittee on Populations meets periodically and focuses on population-based health issues, including those pertaining to racial and ethnic minorities.

Activities: ASPE staffs the *NCVHS* and co-leads the *Subcommittee on Populations* with the Office of Minority Health. The Subcommittee on Populations has conducted a series of hearings to investigate the collection and use of data on racial and ethnic groups by data systems funded by HHS.

Expected Outcomes: In November 2005, the Subcommittee released a report entitled: *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Primary Language in the U.S.* that can be found on the web at: http://www.ncvhs.hhs.gov/051107rpt.pdf

Divisions and Other Groups Involved in Addressing Priority: The Subcommittee on Populations includes experts from the private sector and representatives from HHS Operating and Staff Divisions.

PRIORITY: **Health Promotion and Disease Prevention**

Project 1:

Objective: To exchange information between the U.S. and Mexico about the causes, prevention and treatment of type 2 diabetes among indigenous populations.

Background: In early 2005, Canada, U.S. and Mexico established the Security and Prosperity Partnership of North America. An objective of this partnership is to improve the health of indigenous people through targeted bilateral activities including health promotion, health education, disease prevention, and research.

Activities: On March 2-3, 2006, ASPE and the National Institute of Public Health of Mexico (INSP) co-sponsored a round table meeting of experts, *Experiences and Challenges in the Prevention and Treatment of Type 2 Diabetes Among Indigenous Populations in the United States of America and Mexico*, held in Cuernavaca, Mexico. The meeting began with five plenary presentations providing background information on U.S. and Mexican indigenous populations and their health care and the causes and prevalence of type 2 diabetes in both general and indigenous populations in both countries. This was followed by two case study presentations each from the U.S. and Mexico, focusing on promising approaches to prevention and treatment of diabetes and/or indigenous health care generally in particular communities. Participants then divided into three work groups, each with a mix of policy makers and researchers from the U.S. and Mexican participants, for more in-depth discussions of the sociological dimensions of diabetes, organizational issues in pertinent health services delivery, and research opportunities. Each of the groups then reported back in plenary session on what has worked, what still needs to be learned and/or applied, and what opportunities there may be for future bi-lateral or tri-lateral collaboration. A wide range of interesting ideas for possible future exploration were raised during the final plenary discussion.

Expected Outcomes: Feedback from round table participants was positive with many ideas offered for possible informal or formal collaborations and other activities in the future. Canada conducted its own meeting on

indigenous health issues with representatives from its First Nations several months later.

Divisions and Other Groups Involved in Addressing Priority: The U.S. delegation was led by the former ASPE Principal Deputy/Acting ASPE and included the IHS Director, IHS Diabetes Program Director, IHS external partnerships expert, diabetes researchers from CDC and NIH/NIDDK, members of IHS's Tribal Leaders Diabetes Committee, Tribal researchers, and Tribal diabetes program experts. AHRQ was unable to attend but provided funding for an additional Tribal diabetes expert to attend. Seven of the 13 U.S. participants are members of U.S. Indian Tribes. The Mexican delegation was led by the General Director of the National Institute of Public Health, and included key experts from that agency, the Secretariat of Health, the National Commission for Indian Development, and FUNSALUD, a Mexican NGO, as well as a number of other non-governmental researchers and practitioners with expertise in health and/or indigenous issues. Several Mexican participants have indigenous ancestry. The Director for Chronic Disease Prevention of the Canadian governmental agency, Health Canada, also attended with one of her staff as observers, to gain experience useful for them to design and conduct similar meetings on indigenous health issues in the future.

Project 2:

Objective: To provide information to help understand the high rates of obesity among AI/ANs, the nature of preventive interventions and their efficacy, and directions for future research.

Background: Studies indicate that AI/ANs of all ages and both sexes have a high prevalence of obesity that has increased over the past few decades. Associations between obesity and adverse health outcomes are well documented. However, a knowledge gap exists with regard to the etiology of obesity in the AI/AN population and effective preventive interventions.

Activities: ASPE's Office of Human Services Policy is supporting an in-house study entitled *Obesity and American Indians/Alaska Natives*. This study is being conducted from January 2005 to Winter 2006. The immediate outcome of this activity is the gathering of information through a review of the literature, discussions with key government personnel involved in obesity prevention programs, and a visit to the Gila River Indian Community of the Gila River Indian Reservation that took place in January 2006.

Expected Outcomes: The product of this study will be an overview paper.

Divisions and Other Groups Involved in Addressing Priority: ASPE's Office of Human Services Policy is coordinating with ASPE's Office of Health Policy on this effort. In addition, key staffs from IHS, CDC, NIH, and USDA are providing information for this study.

Project 3:

Objectives: The goals of this study are to determine the incidence of ischemic heart disease among Alaska Natives, to assess the prevalence of risk factors among this population presenting with coronary heart disease, and to evaluate the compliance with established treatment guidelines.

Background: Few studies exist that examine the incidence of ischemic heart disease in the AN population. The prevalence of unhealthy lifestyles among ANs has increased as Western lifestyles have been adopted. Mortality rates from coronary heart disease have remained constant among ANs over the past 20 years, while over the same period, rates have declined dramatically among U.S. whites. Furthermore, currently, secondary prevention measures are not implemented in a systematic way. Collection of baseline data will assist in both documenting the need for prevention, as well as evaluating the effectiveness of interventions.

Activities: ASPE's Office of Health Policy transferred funds to IHS to conduct a study entitled: *Ischemic Heart Disease Among Alaska*

Natives: Incidence, Survival, Mortality and Secondary Prevention. The key activities involved in this study include: 1) comparing and contrasting the incidence of myocardial infarction (MI), its severity and subsequent outcomes among ANs and other populations using surveillance methods; 2) monitoring the incidence of manifestations of ischemic heart disease; and 3) monitoring American Heart Association /American College of Cardiology guidelines among ANs diagnosed with ischemic heart disease. The immediate outcome is the collection of statewide data on MI and other new-onset ischemic heart disease for 2003 and 2004.

Expected Outcome: A final report will be submitted in late December, 2006.

Divisions and Other Groups Involved in Addressing Priority: Along with IHS and the Alaska Tribal Epidemiology Center noted above, staff and patients involved with the Alaska Native Medical Center (ANMC) are involved in this project. The ANMC serves AI/ANs who live in Alaska.

PRIORITY: Legislation

Objective: To assist with efforts to re-authorize the Indian Health Care Improvement Act

Background: IHS has permanent, but general, statutory authority to operate under the Snyder Act. The Indian Health Care Improvement Act (IHCIA) provides more detailed authority, but must be reauthorized periodically (typically on a relatively long cycle – about every 10 years).

Activities: ASPE Health Policy staff working with other parts of the Department conducted analyses, developed Administration positions and alternative approaches to address issues in the legislation, and provided technical assistance within the Administration and to Congressional staff (upon request) on various proposed statutory provisions.

Expected Outcomes: Revisions to the proposed legislation are intended to better address specific needs of Indian beneficiaries and Indian health program providers in ways that are cost-effective, take into account the differing needs of various types and locations of Indian health programs, and are likely to work well both for IHS-funded programs and those of other involved programs and agencies.

Divisions and Other Groups Involved in Addressing Priority: Within HHS, IHS, the Office of the Assistant Secretary for Legislation, and the Office of the General Counsel/Legislative Division played lead roles, with participation from CMS, ASPE, ASRT, HRSA, OIG, and various other General Counsel offices. The Department of Justice and the White House Office of Management and Budget and the Domestic Policy Council also actively participated.

Agency for Toxic Substances and Disease Registry (ATSDR)

PRIORITY* 2: *Increased Access to ATSDR Programs

Objective: Promote within Indian Country a better awareness of ATSDR and its programs.

Background: Often tribal governments and people are alerted to the regulatory work conducted by the US Environmental Protection Agency (EPA) and inquire from EPA answers to the public health significance of contaminants present in their environment. Both regulators and tribes are becoming more aware of ATSDR's expertise in environmental public health.

Activities: ATSDR works with the Community Tribal Subcommittee (CTS) to the Center's Board of Scientific Counselors (BSC). The CTS members include BSC members and representatives from communities and tribal peoples. The CTS advises and discusses with the agency ongoing and planned tribal initiatives. For example, the CTS has provided comments and ideas for the Center's new Environmental Justice Policy, and has integrated tribal-specific questions into the BSC's program

peer review of agency-wide public health practice and research programs.
Also, Agency staff attend national meetings that focus on tribal environmental concerns (Alaska Forum on the Environment and National Tribal Environmental Council) to work collaboratively with others addressing tribal environmental public health issues.

Expected Outcomes: Increased Tribal requests for ATSDR services.

PRIORITY 3: Health Promotion and Disease Prevention

Objective: Decrease or eliminate tribal communities' exposures to hazardous waste in the environment which could result in adverse health effects.

Background: Working in the field, directly with tribal governments and communities, and also using other forms of communication, the Agency strives to address issues of environmental contamination exposures. Environmental media that may be sources of exposures – air, water, soils, and traditional foods – are considered, along with tribal-specific sources, such as plants which are harvested for ceremonial and cultural purposes. Both cancer and non-cancer health outcomes may be associated with exposures to toxic chemicals. Tribal concerns are related to how much exposure is occurring and whether those exposures are potentially harmful.

Activities: Exposure evaluations, usually in the format of a Public Health Assessment or Public Health Consultation report, are completed by agency staff or by recipients of agency externally funded programs (cooperative agreements). This fiscal year, we have responded to tribal concerns of mining waste on tribal lands, contamination of traditional foods, and areas of tribal lands affected by prior industrial usage.
More rapid responses may also be provided as technical assists to the tribes. Health education is also conducted. Tribal consultation is an integral component of any product addressing tribal issues. In addition, research is ongoing to determine particular exposures and toxicities of contaminants in these tribal exposure pathways.

Expected Outcomes: An increased understanding of any potential risk of adverse health effects to tribal people due to environmental contaminant exposures and an increased promotion of healthy behaviors to reduce and/or prevent further harmful exposures.

PRIORITY 4: Recruitment and Retention of Healthcare Providers

Objective: To increase the workforce needed to address tribal environmental public health issues.

Background: The numbers of individuals trained to conduct environmental, scientific, public health evaluations in Indian Country is severely under the needs for such public health expertise.

Activities: ATSDR has a cooperative agreement with the Gila River Indian Community funding the Tribe to hire needed personnel and we also assist with training staff to develop the environmental public health expertise to address issues of chemical exposures. Similarly, our cooperative agreement program funds a collaborative effort for the Alaska Division of Public Health and the Alaska Native Tribal Health Consortia to respond to environmental public health concerns of Alaska Native peoples. We also promote building the tribal environmental public health workforce through our cooperative agreements with Tribal Colleges and Universities (TCUs). The TCU programs are developing associate degree programs in this field. And, we sponsor AISES students to work in our agency and experience the environmental public health practice to alert them to careers in this area.

Expected Outcomes: Self-governance of tribes to conduct their own environmental health assessments.

PRIORITY 6: Data and Research

Objective: Determine, reduce, and prevent adverse health effects from exposures to toxic chemicals.

Background: This research is focused on vulnerable populations, such as Native populations that consume affected biota in their traditional lifestyles. A Congressionally-mandated public health research program, the ATSDR Great Lakes Human Health Effects Research Program, is specifically studying the exposures to toxic chemicals via fish consumption in the Great Lakes.

Activities: The multi-year research program is now shifting emphasis to prevention/intervention activities. However, analyses of collected samples continue to generate data critical to understanding the ongoing exposures in the Great Lake basin. Activities include health departments, academic institutions and tribal governments in the basin.

Expected Outcomes: Changes to environmental public health policy and development of tribal-specific cultural messages and guidelines on fish consumption.

Centers for Disease Control and Prevention (CDC)

***PRIORITY 1*: Funding and Related Issues**

Objective: Manage the Centers for Disease Control and Prevention's (CDC) fiscal and personnel resources in a manner that maximizes impact on the health and safety of American Indian/Alaska Native (AI/AN) people, accurately monitor CDC resources allocated to benefit AI/AN communities, and make this information readily available to tribal leaders.

Background: In addition to a new strategic focus on health impact, another of CDC's six new strategies is accountability. This means that CDC will work to sustain people's trust and confidence by making the most efficient and effective use of the public's investment in CDC. Improved accountability and better management of resources devoted to AI/AN populations will strengthen CDC efforts to improve public health in Indian country.

Activities: (1) CDC is using a portfolio management approach to its resources devoted to AI/AN health issues. This approach will improve how CDC tracks and displays its AI/AN resource commitments (see below). Also as part of this approach, CDC will more closely monitor funds distributed to state health departments via CDC grants and cooperative agreements to help ensure that AI/AN communities receive appropriate benefit from CDC funds. (2) CDC will continue to submit to the Department of Health and Human Services (HHS) and tribal leaders an annual tribal budget and consultation report that includes a summary of CDC resources committed to programs that benefit AI/AN communities. This information will portray fiscal information as committed by CDC's various organizational components and by defined categories. The latter will include a summary of grants and cooperative agreements awarded directly to tribes and tribal organizations.

Expected Outcomes: Better management and improved flow of resources will help to maximize the health impact of CDC programs/projects that focus on AI/AN populations. Increasing transparency in CDC's AI/AN resource allocation process and outcomes will facilitate tribal awareness of, and participation in, CDC efforts to address tribal public health issues.

***PRIORITY 2:* Increased Access to CDC Programs**

Objectives: Eliminate barriers and improve tribal access to CDC's extramural funding opportunities.

Background: In order to take full advantage of the many opportunities that CDC offers for public health support, tribal leaders need to know what those opportunities are and how best to access them. Extramural funding through grants and cooperative agreements is a key mechanism for tribal access to CDC resources.

Activities: All CDC program announcements are now available for viewing and application submission through www.grants.gov. In addition, CDC is working with tribal organizations such as the National Indian Health Board (NIHB), and networks such as the Tribal Epidemiology Centers, to help ensure that news of program announcements is reaching more potential applicants from Indian country. CDC program announcements now contain standardized language specifying tribal eligibility for most program announcements.

Expected Outcomes: These activities will produce (1) an increased number of tribal applications/proposals from Indian country in response to CDC program announcements, (2) a broader spectrum of tribal awardees (tribal governments, tribal organizations) and (3) a more accurate measure of CDC's extramural funds that support programs in Indian country.

PRIORITY 3: **Health Promotion and Disease Prevention**

- **Cancer Prevention**

Comprehensive Cancer Control for AI/ANs

Objective: To promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer.

Background: The significant growth of cancer prevention and control programs within health agencies has resulted in recognizing that improved coordination of cancer control activities is essential to maximize resources and achieve desired cancer control outcomes. Comprehensive cancer control results in many benefits, including increased efficiency for delivering both public health-related messages and services to the public.

Activities: The National Comprehensive Cancer Control Program (NCCCP) is a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. Special activities include CCC Leadership Institutes (CCCLI) focusing specifically on the needs of AI/AN populations. During the interactive institute, six leadership modules were presented that focused on issues and strategies addressing planning and implementation of tribal cancer control plans. The featured speakers and program presenters were American Indians or Alaska Natives. Prior to the Institute, a planning committee of National Partners and AI/AN members ensured that all content was culturally relevant and applicable for Indian country. The first three-day CCCLI was for individuals engaged in cancer control coalition efforts in tribes currently funded by CDC to develop, prepare to implement, or implement comprehensive cancer control initiatives. Another CCCLI was held in October 2006.

Expected Outcomes: These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients. One outcome of the first CCCLI was the formation of the "Comprehensive Cancer Control American Indian/Alaska Native Workgroup." The Workgroup will develop a toolkit providing information on how states can work effectively with tribes and tribal organizations and how tribes and tribal organizations can work effectively with states. The Workgroup will develop educational forums on "Working Effectively with AI/AN Tribes and Communities," which will include developing sessions for June and February CCCLIs.

Breast and Cervical Cancer Early Detection for AI/AN Women

Objective: Assist AI/AN women to gain access to lifesaving screening programs for early detection of breast and cervical cancers.

Background: To help improve access to screening for breast and cervical cancers among underserved women, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which created CDC's National Breast and Cervical Cancer Early Detection Program

(NBCCEDP). The Act was amended the following year to include AI/AN women. This program provides both screening and diagnostic services, including clinical breast examinations, mammograms, Pap tests, surgical consultation, and diagnostic testing for women whose screening outcome is abnormal. Referral for cancer treatment is also provided to women diagnosed in the Program.

Activities: NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. Approximately 57 percent of women screened through the program were of racial or ethnic minority groups, and 4.2% were AI/AN women. NBCCEDP currently funds 13 Native American/Alaska Native organizations. From 2001-2005, these 13 organizations provided 91,023 Pap tests and 46,607 mammograms to 52,230 unduplicated women and detected 218 breast cancers, 7 invasive cervical cancers, and 417 pre-cancerous cervical lesions.

Expected Outcomes: Many deaths from breast and cervical cancers will be avoided by increasing cancer screening rates among women at risk. Timely mammography screening among women aged 40 years or older will reduce breast cancer mortality by approximately 20-25% over ten years compared with women who are not screened. Pap tests can find cervical cancer at an early stage when it is most curable or even prevent the disease if precancerous lesions found during the test are treated.

- **Diabetes Programs**

Technical Assistance for Tribal Diabetes Prevention Programs

Objective: Tribes, tribal organizations, and tribal colleges and universities (TCUs) can easily obtain technical assistance in developing diabetes prevention initiatives.

Background: Discussion groups in 2001 conducted by CDC and the Indian Health Service (IHS) identified a critical, universal need for technical assistance in developing diabetes prevention programs from conceptualization to implementation. The Tribal Leaders Diabetes Committee (TLDC) echoed this need.

Activities: Through contracted services, the CDC Native Diabetes Wellness Program is working to provide culturally appropriate technical expertise in public health program planning and implementation. In addition to an open invitation to tribes, tribal organizations and TCUs to access this expertise, formal consultation is being provided to the eight grantees of the Health Promotion and Diabetes Prevention Projects for AI/AN Communities: Adaptations of Practical Community Environmental Indicators project. The initial meeting among the CDC Wellness Program, McKing Consultants, and the grantees was held in Albuquerque, New Mexico, during November 15–16, 2005. Software support tools developed by the Wellness Program include "CDCynergy: AI/AN Diabetes Edition" and the "Diabetes Atlas: Mapping the Vision of Hope," a Geographic Information Systems tool for communities maintained by the University of New Mexico Earth Data Analysis Center.

Expected Outcomes: Increased utilization of technical assistance resources will build program and infrastructure capacity and sustainability.

The Talking Circles Project

Objective: Training for a program that provides emotional support to community members with and at risk for diabetes is provided across the country, using a tested "Talking Circles" curriculum.

Background: A culturally-rooted, participatory study, "Diabetes Wellness: American Indian Talking Circles" (Talking Circles), which took place on four reservations in South and North Dakota in recent years, represents an ancient way of gathering tribal members in a group such as "talking circles," "council fires," and "talkstories." Directed by Dr. Felicia Hodge and implemented by Ms. Loralei DeCora, the project engages families and community members in a process of listening,

dialogue, and action to impart wisdom and support for members.

Activities: Community health workers—community health representatives (CHRs), diabetes outreach workers—in the Aberdeen, Billings, and Bemidji areas have been trained to serve as "Talking Circle" facilitators in their communities and all interested tribes in the Northern Plains, and Woodlands in Minnesota, Michigan, and Wisconsin have been trained. In addition to Talking Circles training, CHRs and diabetes outreach workers have been provided additional tools including, the "Eagle books" for children, "CDCynergy: Diabetes version for American Indian/Alaska Native Communities" (a software package for health communication program development and planning), "Diabetes Atlas" (a geographic information systems tool to assist communities with surveillance and planning), and the DVD curriculum, "The In-Between People: Including Community Health Workers in the Circle of Care."

Expected Outcomes: It is expected that the "Talking Circles" diabetes curriculum will be used by Community health workers and other health leaders in the Plains tribal communities and some woodland communities (Aberdeen, Billings, and Bemidji IHS areas) to bring awareness to interested groups in their communities.

- **Environmental Health**

Objective: Provide environmental health technical and administrative support to state, county, city, and tribal health agencies in an eight-state region in the western United States and Pacific Rim.

Background: CDC's National Center for Environmental Health (NCEH) funds cooperative agreements to academic centers, such as Loma Linda, to assist state, local, and tribal health agencies to develop effective, state-of-the-art environmental public health programs. The cooperative agreement with Loma Linda focuses on assisting tribes in this regard.

Activity 1: Navajo Nation Environmental Health Surveillance Capacity Building - Loma Linda hosted a Navajo Professor from Dine' College for approximately 1 month. The professor received intensive training in the environmental health applications of geographic information systems (GIS). Dine' College then hosted a Loma Linda graduate student, who trained the college's trainers on the use and applications of GIS. Beneficiary: Navajo Nation.

Activity 2: California's County and City Environmental Health Services Delivery System - This 165-page report provides a comprehensive description of environmental health service delivery in California. Policy and decision makers at the state and local levels are using the report to support a more strategic approach to environmental health management systems. The beneficiaries are the state of California and tribal programs in California.

Expected Outcomes: Environmental public health capacity will be improved in the areas served.

- **Epidemiology and Public Health Practice**

Objective: Continue to place qualified professionals in direct assistance/trainee positions with IHS and tribal organizations.

Background: CDC offers several training programs whose assignees/trainees contribute to health promotion and disease prevention in Indian country. Examples include the Epidemic Intelligence Service, the Preventive Medicine Residency Program, and the Public Health Prevention Specialist Program. For several years, CDC has assigned professional trainees to work with the IHS Division of Epidemiology and Disease Prevention in Albuquerque, New Mexico, and recently has expanded these assignments to include tribal organizations.

Activities: Existing and future trainees working in Indian country will provide increased technical assistance to IHS and tribes in epidemiology, training, and building epidemiologic capacity. In particular, working relationships with the Tribal Epidemiology

Centers will be strengthened as a pathway for bringing CDC technical expertise to tribal communities.

Expected Outcomes: Strengthened public health infrastructure and epidemiologic capacity in national and regional organizations will positively impact public health services provided to AI/AN communities.

- **Fetal Alcohol Syndrome (FAS)**

Objective: Reduce the incidence of FAS in Northern Plains AI/AN children.

Background: Alcohol use during pregnancy continues to be a problem for some AI/AN communities. Programs are needed to educate communities about the effects and prevention of FAS, as well as its identification and management.

Activities: In collaboration with Black Hills State University, Little Wound School on the Pine Ridge Reservation agreed to participate in the pilot testing of a school-based curriculum for students in grades 5-8, based on "Making the Right Choices: A Grade 5-8 Fetal Alcohol Syndrome Prevention Curriculum," developed and used in the Frontier School Division of Canada. In addition, a curriculum was developed and used to conduct a two-day workshop for teachers, juvenile justice workers, and others who might have responsibilities for working with young people with FAS. In collaboration with the University of South Dakota, AI communities in Rosebud, Standing Rock, and Turtle Mountain Chippewa participated in the development of a media campaign to promote a toll-free helpline for women of childbearing age to either reduce their drinking or to increase family planning. In fiscal year (FY) 2006, implementation of the surveillance component of the project occurred as well as the tracking system for linking affected individuals with appropriate community services.

Expected Outcomes: Trainings/workshops for educators, juvenile justice workers, social service workers, foster care and adoption workers, justice system workers, and others who work with children and youth with FAS and their families, will continue in an effort to improve care for those affected by FAS. A media campaign designed to engage AI/AN women in the project will provide a toll-free number for women to call for support in decreasing alcohol consumption and/or increasing effective contraception use.

- **HIV Prevention: Native Peoples**

Objective: To promote HIV prevention in AI/AN communities.

Background: In FY 2006, the National Center for HIV, Hepatitis, STD, and TB Prevention's (NCHHSTP) Division of HIV/AIDS Prevention (DHAP) continued to work with AI/AN leaders from the Native People's Alliance in conjunction with DHAP's National HIV/AIDS Partnership (NHAP) activity. The Native Peoples Alliance is one of several alliances within NHAP.

Activities: NHAP continues to recruit and collaborate with AI/AN leaders. To date, AI/AN leaders representing business, faith, tribal, civic and social organizations are actively involved in partnership activities. AI/AN partners recruited in 2006 include
Rev. Alvin Deere, executive director of the Native American International Caucus, and Wallace Coffey, the chairman of the Comanche Nation of Oklahoma. In addition,
Rev. Marlene Whiterabbit Helgemo, Minister of All Nations Indian Church, attended the CDC Consultation on Faith and HIV Prevention in February of 2006. AI/AN leaders like Karen Hatcher, president of Pequot Health Care, continue to play an integral role in reaching out to other AI/AN leaders in order to engage them in HIV/AIDS prevention awareness activities. Finally, the 2006 Red Ribbon Leadership Awards was held on World AIDS Day, December 1st, at the National Museum of the American Indian. The awards serve to increase awareness of the importance of leadership in HIV/AIDS prevention. The venue also serves as an opportunity to call attention to the impact of HIV on AI/AN and other communities of color.

Expected Outcomes: CDC will continue to disseminate public service announcements, posters, and related print media to promote HIV prevention within AI/AN communities. NHAP will continue to expand its collaboration with AI/AN leaders and communities in an effort to increase HIV/AIDS awareness where AI/AN and other communities live, work, play, and worship. Recruiting AI/AN leaders from diverse sectors to disseminate HIV awareness and prevention messages will remain a top priority in fiscal year 2007.

- **Immunizations**

Objective: To help ensure that AI/AN children benefit fully from Vaccine for Children (VFC) services and to accurately monitor immunization coverage/utilization.

Background: In FY 2006, the VFC program purchased more than $2 billion in vaccines for children birth through 18 years of age who are eligible for the VFC entitlement, which includes all AI/AN children. Based on state population estimate surveys, CDC estimates that AI/AN children make up 2.45% of the VFC eligible population 0 – 18 years of age. AI/AN children receive VFC services through both IHS and non-IHS providers and facilities.

Activities: Coverage and utilization data for AI/AN populations are monitored through the IHS immunization registry, the National Immunization Survey, and state immunization registries. CDC is working with IHS staff and state immunization registries to develop software to allow the electronic exchange of immunization data between IHS, Tribal, and Urban Indian Health (I/T/U) facilities and state immunization registries. The software is currently operational in five states, with further expansion expected.

Expected Outcomes: The inclusion of immunization data from I/T/U facilities into state immunization registries will improve patient care for this population, allow for more complete information on immunization coverage at the state level to monitor potential disparities, and conserve resources.

- **Infectious Diseases in Alaska Natives**

Objective: Prevention and control of infectious diseases in Alaska Natives.

Background: The Arctic Investigations Program (AIP) located in Anchorage, Alaska, is one of three U.S. field stations operated by CDC's Coordinating Center for Infectious Diseases. Core program activities include surveillance of infectious diseases, public health research, health communication and education, public health emergency preparedness and response, and bioterrorism preparedness and response.

Activities: AIP maintains a statewide surveillance system for invasive diseases caused by certain bacteria: S*treptococcus pneumoniae, Haemophilus influenzae, Neisseria meningitidis*, and Groups A and B Streptococcus. In Alaska, the infant pneumococcal vaccine (PCV7) was introduced in 2001 and disease rates due to vaccine types declined by 85 percent among children under 2 years of age. However, the adult pneumococcal vaccine remains underutilized. For example, surveillance identified an outbreak among unvaccinated adults for whom vaccine was indicated but not received by 50% of outbreak cases. Clusters of invasive *H. influenzae* type A infections have been identified through surveillance among Alaska Natives, and rapid case investigations/interventions are linked to an intact surveillance system. *N. meningitidis* remains an important cause of bacterial meningitis for which a new vaccine has recently been introduced. Surveillance data indicate that 57% of early-onset group B streptococcus (GBS) cases in Alaska were preventable through use of national guidelines for prenatal screening and treatment. These findings promoted an educational effort by AIP and the Alaska Department of Health and Social Services to increase awareness among Alaska healthcare providers regarding appropriate diagnosis and treatment of perinatal GBS disease.

Surveillance is needed to determine whether this education can reduce rates of GBS disease.

Expected Outcomes: Vaccine policies and programs need ongoing high quality data collection to be responsive to changes in disease trends. With continued surveillance for these diseases, AIP will assess vaccine program effectiveness, monitor for the emergence of bacterial types not covered by current vaccines, and test for the development of drug resistant strains. The impact of the newly introduced vaccine against *N. meningitidis* will be determined through disease surveillance.

- **Injury Prevention**

Prevention of Motor Vehicle Injuries

Objective: The purpose of the program is to design/tailor, implement, and evaluate AI/AN community-based interventions with demonstrated effectiveness for preventing motor vehicle injuries.

Background: Unintentional injuries are the third leading cause of death among AI/AN populations of all ages combined, with motor vehicle crashes accounting for about half of those deaths.

Strategies to prevent motor vehicle injuries include (1) reducing alcohol-impaired driving among high risk groups; (2) increasing safety belt use among low-use groups; and (3) increasing the use of child safety seats and booster seats among low use groups.

Activities: Beginning in FY 2004, CDC's National Center for Injury Prevention and Control (NCIPC) has funded four tribes (Ho-Chunk Nation, White Mountain Apache Tribe, Tohono O'odham Nation and San Carlos Apache Tribe) to develop, implement, and evaluate tailored, community-based interventions with demonstrated effectiveness to reduce motor vehicle-related injuries among AI/AN populations. This project has a four-year project period.

Expected Outcomes: Each participating tribe will reduce injury and deaths due to motor vehicles and increase seat belt and booster seat use.

Reduction of AI/AN Injury Disparities

Objective: Reduce injury disparities among AI/AN populations by providing technical assistance to IHS and tribes in injury epidemiology, training, and building capacity in injury prevention.

Background: Since 1985, CDC and IHS have had an interagency agreement to help reduce the injury disparities among AI/AN populations. IHS details one Injury Prevention Specialist to CDC's NCIPC to work on injury epidemiology, to conduct special studies with IHS and tribes, and to provide training and technical assistance.

Activities: Through the intra-agency agreement, NCIPC has published several documents that assist IHS and tribal staff with injury program management.

Expected Outcomes: The agreement will continue to help reduce injury disparities among AI/AN population.

Suicide Prevention Program Evaluation

Objective: Reduce injuries and deaths among AI/AN populations by providing enhanced evaluation on suicide prevention programs.

Background: In 2006, CDC and the Substance Abuse and Mental Health Services Administration (SAMSHA), using funding from the Garrett L. Smith Memorial Act, established a collaboration for the support of several sites to perform enhanced evaluation of suicide prevention programs.

Activities: NCIPC is funding The Native American Rehabilitation Association (NARA) in Portland, Oregon for a period of three years. NARA will be collaborating with nine federally recognized AI communities in Oregon to assess whether the range of suicide prevention activities implemented in these communities will

enhance protective factors and/or reduce risk factors for suicidal behavior among AI youth.

Expected Outcomes: Continued agreement and activities for a period of three years will reduce suicidal behavior among youth.

- **Occupational Safety and Health**

Objective: Enhance the capacity of Navajo model farmer "opinion leaders" to provide consulting expertise to intervention group farmers through training, equipment, and supplies.

Background: Model Farmer Dissemination Project: Until the late 1990s, pesticide and herbicide use was minimal on the Navajo Nation. With the spread of invasive weeds threatening the long-term environmental stability and health in the Four Corners region, devastating infestations of grasshoppers and cutworms in recent years have brought about enhanced use and interest in pesticides. Prior work with this population reinforces the importance of using traditional methods to increase the capacity of farmers to use pesticides and herbicides safely and properly. Experience on the Navajo Nation over the last four years has provided the preliminary data needed to build a theoretically derived intervention, based on traditional methods of adult learning. CDC's National Institute for Occupational Safety and Health (NIOSH) is working with a cohort of farmers and ranchers who have asked NIOSH to continue working with them to improve health and safety on their farms.

Activities: 1) Undertake a case/control intervention with Navajo farmers to assess the effectiveness of best management practices and pesticide safety application procedures on farm yield, safety behaviors, and environmental effects; 2) Develop recommendations about "model farms" and "model farmers" that can be used to disseminate best practices to neighboring farmers on the Navajo Nation and to other culturally differentiated groups where health disparities may be common.

Expected Outcomes: Results of the study will be used to develop recommendations about "model farms" and "model farmers" that can be used to disseminate best practices to neighboring farmers on the Navajo Nation and to other culturally differentiated groups where health disparities may be common.

- **Racial and Ethnic Approaches to Community Health (REACH) Programs**

Racial and Ethnic Approaches to Community Health (REACH) 2010 is one of the cornerstones of CDC's efforts to eliminate racial and ethnic disparities in health. REACH 2010 is designed to eliminate disparities in the following six priority areas: cardiovascular disease, immunizations, breast and cervical cancer, diabetes, HIV/AIDS, and infant mortality. REACH programs for tribal communities focus on tribal community capacity building and include the following:

Breast and Cervical Cancer Prevention – Southwest United States

Objectives: 1) To improve collaboration and communication between tribal health programs and the scientific community, 2) to increase public health skills among community health providers, 3) to develop more effective cancer screening programs, and 4) to design and implement community-based preventative interventions. build tribal community and scientific capacity to address the rising incidence of breast and cervical cancer among American Indian women.

Background: This program is supported through Albuquerque Area Indian Health Board and the following communities it represents and serves: Alamo Band of Navajos, TóHajiilee Band of Navajos and Ramah Band of Navajos; Mescalero Apache Tribe; Jicarilla Apache Nation; Ute Mountain Ute Tribe, and Southern Ute Indian Tribe. In recent years, AAIHB has expanded its service base to include the urban American Indian population of Albuquerque, New Mexico.

Activities: Program activities include public health skills building courses, breast and cervical

health training, community needs/capacity assessment, public health infrastructure strategic planning, and community outreach. To date, this project has created a model for developing public health capacity within tribes and has established sustainable networks and partnerships within tribal communities and between tribes and relevant outside programs and academic institutions. Program partners have also significantly raised awareness and improved screening behavior among tribal women, and changed cultural beliefs about "the sore that does not heal."

Expected Outcomes: Tribally-specific preventive interventions will be developed to raise cancer awareness and improve screening behavior, and increase tribal scientific capacity.

Cardiovascular Disease Prevention – Choctaw Nation

Objective: In building capacity, the project has spearheaded the formation of six coalitions in Choctaw Nation Communities within the 10 ½ county jurisdictional area of the Choctaw Nation.

Background: This program works to identify the burden of cardiovascular disease (CVD), assess the adequacy of prevention efforts, and implement improved prevention and treatment strategies for CVD within the Choctaw Nation of Oklahoma (CNO) Boundaries. More than 80,000 American Indians reside inside the CNO Boundaries, and there are more than 395,000 American Indians in the state of Oklahoma.

Activities: Partnerships have been established within the Choctaw Nation Health Services, the Diabetes Wellness Center, community health representatives, and lay health advisors. The program has successfully worked with resource partners to establish 12 community coalitions within the 11 counties of the CNO to raise awareness about CVD prevention, improve access to care, and assess the communities' greatest health needs. It has also developed an innovative educational program that increases awareness about CVD prevention and addresses the established needs of each community surveyed. Substance abuse education was identified as one of the greatest health needs within CNO. The project has exceeded expectations by developing six sustainable coalitions.

Expected Outcomes: The formation and implementation of interventions will promote coalition building, enhance scientific capacity, strengthen use of data supported prevention efforts, and build partnerships and networks. This program will continue to raise awareness about CVD prevention by sharing the community capacity plan, both locally and nationally, with other tribes, school systems, coalitions and public events. The Choctaw Nation also plans to work with partners like Colorado State University's Center for Applied Studies in American Ethnicity to integrate CVD prevention into college curriculums.

Cardiovascular Disease Disparities in Alaska Natives

Objective: The Chugachmiut Native Organization of Alaska works to increase the ability of Chugach region communities to reduce disparities in CVD outcomes.

Background: Chugachmiut Native Organization serves seven rural and remote Alaska Native communities in the Prince William Sound, Resurrection Bay, and Lower Cook Inlet areas of Alaska. All but two villages are accessible only by plane. They provide health and social services, education and training, and technical assistance to the Chugach native people in a way which is acceptable to native cultural values and tradition. As of 1999, heart disease was the third leading cause of death for Alaska Native men, and the second leading cause of death for Alaska Native women. Alaska Natives are the only racial group with a rate of cardiovascular disease much higher than the U.S. rate. Alaska Natives are more likely to be smokers, to be physically inactive and obese, and less likely to be screened for high cholesterol than non-Natives.

Activities: Train a person in each REACH community to be a Community Wellness

Advocate through the one-year distance training offered by University of Alaska in Sitka in conjunction with the Southeast Alaska Regional Health Consortium. Partner with local village tribal councils, Community Health Aides, Community Health Representatives, and other itinerant providers for project support. Work to develop and implement culturally appropriate community programs and activities to increase awareness of CVD and promote healthy lifestyle changes. Conduct community health assessments, as well as provide technical assistance and training to guide local interventions in all Chugach region communities. Development of a yearly interactive "Take the Idita-Heart Challenge" Calendar. Implementation of 312 cardiovascular disease prevention community events. Management of more than 3,000 Community Wellness Advocates and cardiovascular disease education contacts. Completion of 535 cardiovascular awareness tests with post-tests demonstrating an increase in knowledge among participants.

Expected Outcomes: Chugachmiut will continue to educate Alaska Natives in the region about CVD and other chronic disease problems as well as continue to disseminate project information and lessons learned from the project to local, regional, and national audiences.

Diabetes in AI/AN Elders in New Mexico

Objective: The project, administered by the National Indian Council on Aging (NICOA), serves American Indian elders living in New Mexico. The Diabetes Education and Outreach Strategies (DEOS) project works to promote awareness of the need to adopt healthy living practices and good personal diabetes management strategies and offers technical assistance to help mobilize communities.

Background: Among AI/ANs in all age groups, the prevalence of diabetes is 2-4 times higher than among non-Hispanic whites, and they suffer from higher rates of diabetes complications than all other ethnic groups. The risk of developing diabetes increases with age; rates increase from 3.5% for AI/ANs aged 20-44 years to over 20% for AI/ANs aged 65 or older AI/ANs have significantly higher prevalence of health risk factors such as obesity, smoking and lack of physical exercise than other ethnic groups.

Activities: DEOS trained community members on 10 reservations to begin and maintain diabetes support groups with training materials modified to fit the needs of each community. Over 66% of participants said the support group helped them maintain their eating and physical fitness goals. The project provided technical assistance to American Indian diabetes programs by supporting capacity building for outreach, and fostering partnership development with community organizations that share common goals to help elder's live healthier lives.

Expected Outcomes: NICOA will develop a roadmap to help tribal program participants assess their community's level of readiness to address diabetes prevention. The stage of readiness will indicate to local leaders what approach they should take before they plan for capacity building. This roadmap will accompany an instrument for community needs assessment providing clear guidelines for determining how to evaluate health care plans with measurable outcome indicators. DEOS will create targeted marketing materials that can be used by community programs for advertising prevention activities and bringing awareness to prevention activities within the community.

Diabetes and Cardiovascular Disease Prevention – Oklahoma Tribes

Objective: Oklahoma's REACH 2010 Coalition partners represent eight AI tribes/nations, one urban Indian health center, and the Oklahoma State Department of Health, Chronic Disease Service. The main goal of the Oklahoma REACH 2010 Project is to reduce disparities in cardiovascular disease and diabetes through the expansion and implementation of primary and secondary prevention interventions of physical activity, nutrition, and smoking cessation.

Background: The age adjusted diabetes mortality rate is nearly 200% higher among the AI/AN population than whites (2001 Oklahoma Vital Statistics). The prevalence rate of diabetes among Oklahoma adults is 13.1% for AI/AN, compared to 7.0% for whites, and the obesity prevalence rate is 31.6% for AI/AN, compared to 22.2% for whites (BRFSS 2001 and 2003).

Activities: Reduce racial disparities in diabetes, cardiovascular disease, and their risk factors through increased availability and promotion of physical activity on a community level. The program includes physical fitness/wellness programs in all nine communities, at least one Physical Fitness Specialist or equivalent trained in each community, establishing policy/environmental changes in all communities, collecting baseline and follow-up measurements on participants, continued formal education of staff, and education of participants about the importance of physical activity and nutrition. Over 5,000 participants are enrolled in Oklahoma's REACH 2010 Project. Collectively all nine REACH partners have 23 trained and certified staff who have successfully implemented over 75 physical activities per week. Over 75 tribal staff and community members have been trained in fitness and health promotion. All partners have employee fitness/wellness programs and have implemented secondary prevention programs related to nutrition, smoking cessation and obesity. All partners have implemented environmental changes such as tobacco policies, employee fitness policies, and healthy food policies. Community partners have received over $2 million dollars in additional funding to expand and enhance their programs. Dissemination has included 34 national presentations, 2 international presentations, 3 peer reviewed articles, 1 book chapter, and 2 reports.

Expected Outcomes: This program will reduce racial disparities in diabetes, cardiovascular disease, and their risk factors through increased availability and promotion of physical activity on a community level. Future plans of the Oklahoma Native American REACH 2010 Project will include sustaining programs, institutionalizing activities, sharing with other Native communities, and moving into the larger community.

Healthy Lifestyles and Diabetes Prevention – Eastern Band of Cherokee Indians

Objective: Men and women of the Eastern Band of Cherokee Indians (EBCI) are twice as likely to be obese than other North Carolina men and women. EBCI men and women reported a combined type-2 diabetes prevalence rate of 23.8%, more than three times the combined rate for men and women in North Carolina.

Background: In order to mobilize the community to confront environmental and biological factors that put Cherokee people at risk for developing diabetes, a program known as "Cherokee Choices" addresses racism and mental health, creates a supportive environment, and develops health policy changes. A team of mentors works with elementary school children and staff to develop lesson plans for the classroom on self-esteem, cultural pride, conflict resolution, emotional well-being and health knowledge, and develop a weekly after-school program to enhance team-work, cultural awareness and physical health. Nutritionists, dietitians, and fitness workers help tribal workers and church members participate in activities to reduce stress, eat healthier, and increase physical activity.

Activities: Housed in the Health & Medical Division of the Eastern Band of Cherokee Indians, Cherokee Choices is a three-component program: elementary school mentoring, worksite wellness for adults, and church-based health promotion. The cornerstones of the program are listening to the community and providing social support to increase physical activity and promote well-being and healthy choices which reduce the risk of obesity and diabetes. The REACH 2010 intervention in Cherokee focuses on three main components: Worksite wellness, School wellness, and Faith-based wellness. The interventions have succeeded in changing school systems to increase physical activity among the students and staff, decrease the amount of fat in school lunch menus, increase the fresh fruit and

vegetable options in the school lunch menus, and increase parental participation in student activities. Some participants have been able to decrease or eliminate medications for diabetes and or high blood pressure. Also, significant decreases have been found in the percentage of body fat in worksite wellness participants.

Expected Outcomes: Expansion of the worksite wellness program and mentoring program will incorporate more worksites, churches and schools. Anticipate the sharing of knowledge will facilitate development of similar programs with surrounding counties. Intent to seek funding to create a more walk-able community with greenways and sidewalks.

HIV/AIDS Risk Reduction

Objective: The Association of American Indian Physicians (AAIP) REACH 2010 community capacity program aims to reduce the risk of HIV/AIDS among AI/ANs, with an emphasis on youth and prevention.

Background: The coalition, Native Nations United Against AIDS (NNUAA), implements events to increase awareness of HIV/AIDS during World AIDS Day community activities and at cultural events, including a Pow-Wow.

Activities: NNUAA is also developing a speaker's bureau of coalition members trained to conduct basic HIV/AIDS awareness presentations to communities upon request. AAIP also created an educational video and study guide titled: The Phillip Smith Story, to serve as an educational tool for American Indian youth. Over 1,000 community members have attended recent community-based activities sponsored by each coalition. Coalitions have gained the support of traditional tribal members within the communities. 100 American Indian parents brought their daughters to a recent community training. Coalitions have gained the support of the public school system and tribal boarding schools in their regions.

Expected Outcomes: Activities will continue to incorporate faith based and non-Native organizations in the community to raise community awareness, as well as the implementation of Community PROMISE, a community level intervention training that consists of understanding Behavioral Theory and Social Norms, community identification through rapid ethnography, and media development and dissemination.

Reducing Infant Mortality and Improving Immunization Coverage - United Southern and Eastern Tribes (USET)

Objective: To assist tribes in developing local immunization programs to utilize immunization registries, conduct surveillance for immunization coverage and vaccine-preventable disease incidence, and develop community-specific interventions. Assistance includes training and technical support, dissemination of information, and coordination of activities between tribal, local, state, and federal public health resources. Conduct data quality assessment at the tribal level to ascertain and address data weaknesses in the computerized health data management system.

Background: The AI/AN population have higher rates of morbidity and mortality than other Americans. In 2003, the infant mortality rate for American Indians was 8.7 per 1,000 while the U.S. all-race infant mortality rate was 6.8 per 1,000, and the white rate was 5.7 per 1,000 (National Center for Health Statistics data). USET tribal childhood immunization coverage is well below Healthy People 2010 goal. For example, the percentage of 19-35 month olds with age-appropriate complete immunizations for the 4:3:1:3:3:1 (DTP, IPV, MMR, HiB, Hep B, Var) series for calendar year 2005 was 74%, well below the Healthy People 2010 goal of 90%. The incidence of vaccine-preventable disease is not known due to racial misclassification of AI/ANs in state notifiable disease reporting systems and inadequacies in tribal health data systems. Risk factors such as obesity and tobacco use is disproportionately higher in our tribes than in the nation at large.

Activities: Twenty USET tribes are currently involved in the collection of prenatal data to determine what factors may influence infant

death, and 23 are currently involved in the collection of mortality data for linking to birth records. USET is assisting tribes in developing local immunization programs to utilize immunization registries, conduct surveillance for immunization coverage and vaccine-preventable disease incidence, and develop community-specific interventions. Assistance includes training and technical support, dissemination of information, and coordination of activities between tribal, local, state, and federal public health resources. USET is also conducting data quality assessment at the tribal level to ascertain and address data weaknesses in the computerized health data management system. Currently, 83.0% of USET tribes are participating in the infant mortality project. The number of tribes using immunization registries has increased from 9 to 21 and the number of American Indian children tracked for immunization coverage has increased 3-fold. In addition, USET has provided several immunization registries trainings and assisted tribes in gaining access to their respective state immunization registries.

Expected Outcomes: USET will continue to produce and distribute annual tribal-specific and aggregate immunization reports to provide an overview of tribal programs and monitor progress, as well as periodic tribal-specific and aggregate mortality reports.

USET will also continue to provide technical assistance and training for our tribal immunization programs and focus on improving immunization rates at the community level; conduct data quality assessment for each tribe to improve data completeness in the tribal health data system; provide mortality reports to tribal programs; work towards establishing data sharing agreements with state agencies and improve state to tribe relationships; and provide prenatal care and assessment reports and recommendations to tribal programs to improve infant outcomes.

- **Reproductive Health (RH)/Maternal-Child Health (MCH)**

Objective: To carry out activities in epidemiology, surveillance, capacity building, and enhanced data utilization and dissemination that lay the groundwork for improvements in reproductive and maternal-child health among AI/AN populations.

Background: In recent years, CDC's Division of Reproductive Health (DRH) modified its approach to AI/AN health, implementing and supporting more activities that are aimed toward expanding and improving AI/AN RH/MCH in the United States. The new approach has focused on efforts to help overcome obstacles to such activities and assist tribal organizations to make RH/MCH improvements.

Activities: DRH convened a meeting of experts in MCH among AI/AN populations in the spring of 2004 with the goal of raising awareness of the need for enhanced research into this much neglected area. This meeting has led to a number of on-going activities inside and outside DRH. One such activity is the production of a special issue of the Maternal and Child Health Journal that will help publicize AI/AN MCH disparities and develop publication capacity among AI/AN researchers. DRH researchers are studying the effects of smokeless tobacco on pregnancy outcomes in Alaska Native women. DRH staff has explored potential applications of IHS clinical MCH data and have conducted a study of maternal morbidity in IHS facilities using such data. DRH is also playing a lead role in a new international initiative regarding the measurement of health indicators in indigenous populations. In FY 2006 DRH awarded a Pregnancy Risk Assessment Monitoring System (PRAMS) grant to an American Indian group. This is the first PRAMS contract not awarded to a state. Finally, DRH is working with AI groups to improve and standardize death scene investigations for sudden infant death syndrome (SIDS) deaths and working with Tribal EpiCenters to use data to create positive change in tribal communities.

Expected Outcomes: Enhanced research and surveillance activities on MCH and reproductive health among AI/AN population, in both basic epidemiology and programmatic issues, will

improve capacity of tribes and tribal organizations to carry out and publish research in RH/MCH, complete successful MCH epidemiologic studies and improve understanding of measurement issues and data collection among AI/AN populations.

- **STD Prevention and Control**

Objective: To develop a National Coalition of STD Directors (NCSD) subcommittee to better address STD prevention and control efforts among AI/AN populations.

Background: In 2004, CDC and the IHS National STD Program recommended to NCSD that it form a subcommittee of state STD Directors from states with large AI/AN populations to better address STD prevention and control efforts among AI/AN populations. NCSD accepted the recommendation and voted to form this subcommittee in early 2005.

Activities: The AI/AN subcommittee is currently co-chaired by the STD Directors of Minnesota and Utah and has approximately 15 members. CDC and IHS will support NCSD in hiring a contractor to support many of the subcommittee's efforts. In January 2006, JSI Research and Training Institute, in partnership with the Northern Plains Tribal Epidemiology Center (NPTEC) of the Aberdeen (South Dakota) Area Tribal Chairman's Health Board (AATCHB), was awarded a contract to develop AI/AN-specific materials and training. To date, NCSD/JSI have conducted two separate trainings to increase awareness about working in Indian country (one session was conducted at the National STD Conference and one session was conducted at a recent NCSD meeting). In addition, JSI is developing AI/AN fact sheets for all 65 project areas in an effort to educate state STD program managers about the native populations within their respective states.

Expected Outcomes: The NCSD AI/AN subcommittee will facilitate improved education of federal, state, and local policymakers about issues relevant to STD prevention and control measures in AI/AN populations and will foster stronger partnerships between tribal and state public health programs to address STD control in AI/AN communities. These partnerships should lead to the creation of public health and tribal networks that can serve not only the STD issue well, but also other public health issues and emergencies.

- **Tobacco Programs – Tribal Support Centers**

Objective: (1) Increase the capacity and infrastructure of commercial tobacco prevention and control at the tribal/community level using culturally appropriate methods and scientific, population-based strategies. (2) Evaluate promising, culturally competent commercial tobacco programs, curricula and/or strategies that were developed by AI/ANs to serve AI/AN populations in the area of commercial tobacco control and prevention.

Background: In FY 2005/2006 a new round of candidates vied for Tribal Support Center cooperative agreements with CDC's Office for Smoking and Health (OSH). The Request for Proposals differed from the first round of Tribal Support Center funding in that AI/AN tribes and tribal organizations could compete for either capacity-building funding or implementation funding – the latter intended to assist in the sustainability of previously funded Tribal Support Centers. The implementation programs are venues through which culturally competent AI/AN-developed promising practices are implemented inter-tribally and then scientifically evaluated. Capacity Grantees are (1) Cherokee Nation, Tahlequah, Oklahoma (2) Southwest Navajo Tobacco Education and Prevention Program – Winslow, Arizona (3) California Rural Indian Health Board (CRIHB), Sacramento, California and (4) Indigenous Peoples' Task Force (IPTF) – Minneapolis, Minnesota. Implementation Grantees are (1) Muscogee (Creek) Nation – Okmulgee, Oklahoma (2) South East Alaska Regional Health Consortium (SEARHC) – Sitka, Alaska and (3) California Rural Indian Health Board (CRIHB), Sacramento, California.

Activities: Examples of Capacity Grantee activities include training tribal health educators

and IHS providers in commercial tobacco prevention and control efforts, and training tribal community facilitators of *Second Wind*, a culturally competent smoking cessation program. Grantees work with community gatekeepers and tribal governments to develop binding resolutions in the area of commercial tobacco-free policies, educate tribal council members and community gatekeepers in policies that deter youth commercial tobacco use (e.g., raising taxes on cigarettes), and work with tribal police agencies to ensure that tribal smoke-shops do not sell to minors. They facilitate collaborations between tribes, state health departments, other Tribal Support Centers; and state, regional, and national organizations; work with IHS to ensure that protocols regarding commercial tobacco use are put into place and used by providers (e.g., referring AI/AN smokers to cessation classes provided by Tribal Support Centers), and provide resources and technical assistance to tribe and community educators. Programs are also working to integrate commercial tobacco education into other areas of health education, i.e., diabetes, cardiovascular health, physical activity and nutrition, pre-natal care, and are encouraging tribal casinos to produce needs assessments that include areas of interest to casinos (e.g., marketing efforts) but also include commercial tobacco free policy data. Capacity grantees provide mini-grants to community centers, other tribes, youth camps, and the like for their efforts in commercial tobacco prevention and control. Some grantees have developed AI/AN culturally relevant and appropriate materials, tool kits, curricula, media campaigns in the area of commercial tobacco control and prevention. They have worked with state health departments to develop and implement targeted, tailored campaigns using native faces and native languages to urge AI/AN commercial tobacco users to call the quit lines, disseminated information at culturally appropriate venues, e.g., health fairs, pow-wows, community center pot lucks, and integrated popular forms of traditional sports for AI/AN youth with commercial tobacco education.

Examples of Implementation Grantee activities include developing scientifically rigorous, yet culturally competent, evaluation plans; identifying potential evaluation partners and sites; and generating buy-in from potential evaluation partners (e.g., Tribal Councils, State Health Departments, State Quit Line managers, Quit Line Contractors such as Free and Clear). They also have trained cessation facilitators and quit line counselors, implemented evaluations of activities, and monitored these evaluation findings to inform and improve the evaluation plans.

Expected Outcomes: Capacity Grantees activities will increase referrals to cessation classes by IHS and tribal clinic providers, decrease AI/AN youth commercial tobacco initiation, enhance knowledge by tribal members of the adverse health affects of commercial tobacco use, and initiate dialogues regarding commercial tobacco-free policies (this is typically a very sensitive area due to the issue of sovereignty – respect for the sovereign status of the tribes is overarching in this process). These grantees will also implement commercial tobacco-free policies on tribal health campuses, increase the number of cessation facilitators in tribal communities, and increase the number of cessation classes held in tribal communities, rather than just the clinics, which will also increase accessibility for AI/AN smokers. These tribal grantees will also develop culturally appropriate materials, tool kits, curricula, media campaigns and increase use of quit lines by AI/AN tribal members served by the Tribal Support Centers. Most importantly, they will initiate dialogue between the Tribal Support Centers and tribal councils on the issue of raising taxes in tribally owned smoke-shops. (Note that many smoke-shops on tribal lands are owned by individuals rather than tribes.) The implementation grantees are expected to develop promising approaches that will emerge as evidence-based practices.

- **Violence Intervention**

Objective: To create partnerships with communities to support the delivery of intimate partner violence interventions to prevent intimate partner and sexual violence and services for AI/AN communities.

Background: This is a new program with a project period of three years and is intended to assist racial/ethnic minority communities to assess and prevent sexual and intimate partner violence.

Activities: CDC's NCIPC funds the National Indian Justice Center to build capacity for AI/AN communities to prevent intimate partner and sexual violence. There will be an emphasis to work with men and boys in a culturally appropriate manner to prevent these forms of violence before they occur.

Expected Outcomes: Culturally competent demonstration projects for early intervention of both sexual and intimate partner violence will be developed, implemented, and evaluated.

- **Viral Hepatitis Prevention and Control**

Objective: To reduce the morbidity and mortality of disease caused by hepatitis A, B, and C viruses.

Background: *Hepatitis A virus*: Until the hepatitis A vaccine became available in the United States in 1995, the highest hepatitis A rates in the country occurred among AI/ANs (as high as 10 times the national average in some years). In the 1980s and early 1990s, the lifetime risk of hepatitis A virus infection among Alaska Natives living in villages approached 90 percent, and during outbreaks the peak reported incidence exceeded 2,000 cases per 100,000 population. In 1996, the Advisory Committee on Immunization Practices (ACIP) recommended routine hepatitis A vaccination of American Indian and Alaska Native children. CDC and IHS worked first to implement pilot programs and then to achieve high coverage among AI/AN children. Since then, hepatitis A rates among AI/ANs have declined by 99%. In 2004, less than 20 hepatitis A cases were reported among AI/ANs in the entire country. Hepatitis A rates among Alaskans are now similar to rates in other parts of the United States. *Hepatitis B virus*: Before the availability of a hepatitis B vaccine in the mid-1980s, hepatitis B virus infections were very common in Alaska Natives. Many of these infections occurred in young children and caused chronic infection leading to greatly increased risk of liver cancer and cirrhosis. Routine childhood hepatitis B vaccination implemented during the past 20 years with support from CDC and IHS has increased hepatitis B vaccine coverage to high levels and virtually eliminated new cases of chronic hepatitis B virus infection in Alaska Native children. *Chronic Liver Disease*: No vaccine yet exists for hepatitis C, a major cause of chronic liver disease (CLD) and liver cancer among Alaska Natives and American Indians. Other common chronic conditions that can contribute to the development of CLD include hepatitis B, alcoholism and obesity. For AI/ANs, the risk of death from CLD is approximately 2.5 times the national rate, with hepatitis B, hepatitis C, alcoholism, obesity, and other diseases all contributing to this burden. CDC is supporting efforts to determine the causes of CLD, and the factors that contribute to more severe CLD among AI/ANs.

Activities: Evaluate the long term efficacy of hepatitis A and B vaccine administered in early infancy. Assess the prevalence of, and risk factors for, hepatitis C virus infection. Determine the burden and etiology of chronic liver disease. Identify and implement interventions to reduce the burden of disease.

Expected Outcomes: Activities will support and inform the development of vaccine policy (e.g., is a booster dose needed?) to reduce disease incidence and determine methods for identifying chronically infected individuals and link them to care.

PRIORITY 4: **Recruitment and Retention of Healthcare Providers**

- **Professional Clinical Skills Development**

Objective: To train mid-level providers to perform flexible sigmoidoscopy in IHS and tribal health facilities.

Background: This is the second of a two-year CDC–IHS Intra-Agency Agreement. Alaska Natives have the highest incidence and mortality

rate from colorectal cancer in the United States, yet currently there is little screening capacity in rural facilities. This project aims to increase capacity by training primary care providers from rural facilities to address this gap.

Activities: Activities that have occurred thus far include curriculum development for trainees, purchase of screening equipment, training of mid-level practitioners from Kotzebue, Klawock, Juneau, Kenai, and Bethel at the Alaska Native Medical Center; development of a training program brochure; abstracts about the program have been submitted/accepted for the American Public Health Association, Inuit Rural Health Conference, and the Alaska Public Health Summit; baseline rates have been established in all areas for trainee regions; and there is participation in the development of RPMS-based tracking systems.

Expected Outcomes: It is anticipated that screening rates for colorectal cancer will increase for the Alaska Native population based on increased access to these services.

PRIORITY 5: **Emergency Preparedness**

- **Communicable Disease Control**

Objective: To revise federal communicable disease (quarantine) regulations.

Background: The federal regulations that implement CDC's statutory authorities for communicable disease control are in the Code of Federal Regulations (42 CFR, Parts 70, 71). These regulations, which have not been updated in many years, contain no specific provisions regarding Indian country.

Activities: During FY 2005, CDC initiated a tribal consultation process regarding the proposed revisions that included presentations at HHS Regional Tribal Consultation Sessions and the distribution of a Dear Tribal Leader letter from Directors of CDC and IHS. These activities served to advise tribal leaders about the formal release of revised draft regulations in the form of a Notice of Proposed Rule Making (NPRM). The NPRM containing the proposed revisions was released for tribal and public comment early in FY 2006. Tribal leaders' comments were collected and specifically addressed as part of CDC's newly established tribal consultation procedures.

Expected Outcomes: New regulations formed with tribal input will specifically and effectively address the application of these regulations in Indian country. The proposed regulations will continue to undergo internal HHS review. CDC will carefully review more than 500 pages of public comments received and will consider policy options and responses to the hundreds of insightful comments and recommendations received. The time necessary in this process will be taken to fully consider all options before promulgating a final rule.

- **Cross-Border Preparedness**

Objective: To establish cross-border emergency preparedness partnerships with Canada and Mexico.

Background: Communities located on or near international frontiers face unique jurisdictional and organizational challenges when planning for, or responding to, health crises such as pandemic influenza, outbreaks of other infectious diseases, or biologic, radiologic, chemical or bioterrorism events.

Activities: The Early Warning Infectious Disease Surveillance (EWIDS) project is working to enhance surveillance and epidemiological capabilities at the U.S. northern and southern borders, with emphasis on creating interoperable systems with Canada and Mexico. States along the Canadian border participating in EWIDS have had discussions with First Nations (FN) representatives, Health Canada, and provincial partners to support cross border surveillance and epidemiological capabilities with tribal communities on the border, and to ensure their participation in federal-state-provincial planning activities.

Expected Outcomes: Continued focus on EWIDS activities will help to create a greater awareness of the on-going challenges to

effective emergency preparedness and response faced by FN communities located on or near the U.S.–Canadian international frontier.

- **EMS Services**

Objective: The purpose of this program is to support collaboration between national organizations of professionals in acute medical care, trauma, emergency medical services (EMS) with state and local public health programs and CDC in efficiently and effectively responding to mass trauma events resulting from terrorism.

Background: Despite our best efforts to protect the public, large numbers of Americans may be seriously injured in future mass trauma events, such as a large-scale natural disaster, bomb explosion, or disease outbreak. The ability to effectively minimize the impact of such injuries will critically depend upon the appropriate responses of all levels of the emergency medical response system. State and local health systems must also be fully prepared and capable of responding to the public in the event of a potential mass casualty event.

Activities: Since 2004, CDC's NCIPC has funded the National Native Americans EMS Association for Linkages of Acute Care and EMS to State and Local Injury Prevention Programs. This program supports collaboration between national organizations of professionals in emergency care and state and local health departments. These relationships are critical to response to mass trauma events.

Expected Outcomes: Facilitated development of critical relationships related to acute care, trauma, EMS services, and public health will assist CDC to respond effectively to mass trauma events resulting from terrorism.

- **Tribal-Federal AI/AN Task Force**

Objective: To establish an AI/AN Task Force on Bioterrorism and Emergency Preparedness.

Background: Improved coordination across the many federal organizations that play a role in addressing emergency preparedness and response in Indian country would help AI/AN communities and governments to be better prepared. Preliminary discussions among federal and Tribal officials have addressed the possibility of establishing a Tribal-federal task force that would address the issue of collaboration between federal agencies (e.g., CDC, Environmental Protection Agency, Indian Health Service, Federal Emergency Management Agency, Division of Health Studies, Bureau of Indian Affairs, Department of the Interior, Health Resources and Services Administration, Office of the Assistant Secretary for Public Health Emergency Preparedness, Agency for Toxic Substances and Disease Registry) and Tribal governments, Tribal-serving organizations (e.g., National Congress of American Indians, National Indian Health Board, NNAEMS, regional health boards, etc.), and other Tribal entities involved in addressing bioterrorism and emergency preparedness issues.

Activities: During FY 2006, CDC had several discussions/meetings with Tribal and federal partners to discuss goals for the proposed task force. Although a formal taskforce was not organized, ongoing formal collaboration and consultation between each of the OPDIVS and tribal serving entities are occurring -- in particular with the newly created IHS Office of Emergency Services Program.

Expected Outcomes: Continued discussion of finalizing the proposed task force will allow for more consistent communication between federal agencies and Tribal entities, and will facilitate effective, coordinated planning for emergency preparedness and response and pandemic influenza initiatives in Indian country.

PRIORITY 6: **Data and Research**

- **CDC Prevention Research Centers (PRCs)** are a network of academic researchers, public health agencies, and community members that conducts applied research in disease prevention and control. Several PRCs have tribally-focused projects:

University of Oklahoma PRC: TRAILS (The Regular Activity in Life Study) - Obesity

Objective: About 45 Anadarko high school students, 34 of whom are enrolled in the study, are participating in a 16-week elective physical education class which includes a 35–40 minute daily walking or running session. The superintendent and principals support this effort to increase physical activity during school hours.

Background: In Anadarko, Oklahoma, community members and school administrators asked researchers to develop an affordable and effective intervention to prevent and reduce the high rates of obesity among the community's adolescents. Almost half the students in Anadarko's public schools are overweight or at risk of becoming overweight. In the high school, about 60% of the students are American Indian and at especially high risk for developing diabetes.

Activities: Before the intervention, students complete a 1-mile walking test to determine their physical fitness level. They also have their blood pressure taken; random cholesterol, triglycerides, and glucose measured; height and weight measured; and body mass index (BMI) and body composition determined. Project staff will ask students about their program likes, dislikes, and ideas for improvement. Project staffs are also working with the high school administrators and food service personnel to provide students with healthier vending machine and cafeteria food choices.

Expected Outcomes: The overall goal of TRAILS is to serve as a model for school administrators and state and local policymakers that will encourage affordable and manageable programs for in-school physical education classes.

University of Oklahoma PRC: Healthy Kids Screening Project - Obesity

Objective: Track trends over time to determine if any changes have occurred and how many children and adolescents remain at risk for obesity-related diseases.

Background: The school population is more than 60% Native American and about 6% Hispanic. In a project ongoing for several years, the center's faculty, staff, and students have screened about 2,000 students in the Anadarko public schools (elementary grades through high school) for height and weight, and calculated their BMI. Close to 80% of the students are eligible for low or reduced price lunches. In the 2002–2003 school year, half the students were overweight or at risk for overweight.

Activities: Blood pressure measurements have been done twice. Screening is being repeated in the 2005–2006 school year, and researchers will track trends over time to determine if any changes have occurred and how many children and adolescents remain at risk for obesity-related diseases.

Expected Outcomes: Information will be shared with parents and school officials. The findings will serve as the basis for developing new physical activity interventions and promoting changes in nutrition.

University of New Mexico PRC: Teen Health Resiliency Intervention for Violence Exposure (THRIVE)

Objective: The community intervention aims to improve youths' quality of life and reduce the traumatic effects of their exposure to violence. The intervention's focus is on addressing the negative effects of historical trauma experienced by American Indians. Parents, teachers, and community members are being trained to recognize the signs of trauma among youth and get help for them.

Background: Project collaborators developed THRIVE to test the effectiveness of school- and community-based interventions for identifying and reducing psychological distress among American Indian youth who witness or experience violence (such as child abuse or domestic violence). Psychological distress has been associated with heart disease (the leading cause of death among American Indian adults) and suicide – AI/AN youth (aged 15-24 years)

have the highest rate of suicide in the United States.

Activities: The in-school intervention includes an intensive mental health program for 6th to 12th grade students based on the 10-week CBITS program (Cognitive Behavioral Intervention for Trauma in Schools) initially created in California for urban youth in Los Angeles. Center researchers, the community advisory committee, and other project collaborators adapted the CBITS program for American Indian youth. During the intervention, about 30 students who reported symptoms of violence-related trauma on the center's mental health screening questionnaire were referred to an early- or delayed-CBITS group; students reporting other mental health issues were referred to individual counselors at their schools' teen health centers. Students participating in the CBITS intervention meet in small groups to share experiences, express feelings, receive group support, and build coping skills. Their parents and teachers are trained to support them at home and in the classroom. Students also meet individually with a mental health counselor as needed. Evaluators will determine whether the program increases students' coping skills; reduces their symptoms of violence-related trauma such as depression and anxiety; and whether positive effects persist 6 months later.

Expected Outcomes: About 20 parents and their children will participate in a 6-month intervention designed to heal historical trauma, improve family relationships, teach positive parenting skills, and reconnect parents and youth with traditional culture—all of which help to increase youth resilience to stress, and may reduce alcoholism, child abuse, and domestic violence. Tribal elders will teach participants about their cultural heritage and history, and reconnecting youth to their traditions through group discussions and communal healing practices. If effective, researchers will develop a program manual and tool kit to disseminate throughout the United States and conduct large-scale effectiveness studies.

University of Oregon PRC: Tribal Vision Impairment Prevention Project (VIP Project)

Objective: This project aims to increase residents' access to eye exams, improve the quality of life for residents who need prescription eye glasses, reduce the risk of blindness for residents who have diabetes, and determine the extent and possible causes of the community's visual impairments.

Background: Visual impairment is the second-leading cause of disability among American Indians living in the Pacific Northwest, and contributes to this population's diminished quality of life by limiting their ability to pursue educational and employment opportunities, social interactions, interests, and hobbies. Only 2 of the 43 American Indian tribes in the Pacific Northwest have an eye care provider, and most tribal members must travel 60 miles or more to have an eye exam.

Activities: To address these issues, the center collaborated with the Tribal Community Advisory Council, the Northwest Portland Area Indian Health Board, and the Devers Eye Institute to design, implement, and evaluate this project. About 450 residents from 3 tribes are participating: Umatilla in Oregon, Shoshone-Bannock in Idaho, and Lummi in Washington. Basic eye exams are performed onsite by a vision technician, and participants who need them, are given free prescription eye glasses and participate in a survey to compare their before and after quality of life scores. Participants with abnormal results are referred to an ophthalmologist at the Devers Eye Institute who conducts a full eye examination and determines the accuracy of the initial results (participants without transportation are taken to the eye clinic or visited at home by an eye doctor). Participants with diabetes receive an in-depth eye exam using a telemedicine technique of taking photographs of the eyes and using a computer to send digital images of the pictures to an ophthalmologist at another location. The ophthalmologist reviews the images, makes a diagnosis, and recommends treatment.

Expected Outcomes: During the evaluation, researchers will find out if brief initial eye exams are accurate and improve the population's accessibility to eye care. They will also determine whether telemedicine is an accurate and feasible method for detecting cataract, glaucoma, diabetic retinopathy, and macular degeneration. Participants will be asked for project recommendations and suggestions for expanding it to other Native communities.

- **Cancer**

Alaska Breast Cancer Study

Objective: Compare levels of organochlorine compounds in Alaska Native women who have breast cancer and those who do not have breast cancer.

Background: Dietary practices may place Alaska Natives at increased risk of exposure to organochlorine compounds. These compounds are being evaluated for a possible role in the development of breast cancer.

Activities: Methodology for analyzing organohalogen compounds in breast adipose tissue will be evaluated and certified. Then the 229 adipose tissue sampled will be analyzed for brominated flame retardants, polychlorinated biphenyls, and persistent pesticides. This project is planned to be completed during the spring of 2006.

Expected Outcome: The project will enhance primary prevention of breast cancer by evaluating the environmental risk factors for this disease.

Breast Cancer and Exposures to Persistent Organic Pollutants (POPs) Among Alaska Native Women

Objective: Compare levels of organochlorine compounds in Alaska Native women who have breast cancer and those who do not have breast cancer.

Background: Alaska Natives may be at an increased risk of exposure to organochlorine compounds because of their diets.

Activities: Samples of blood, urine, and/or breast tissue were used in the study. Participants were interviewed about many topics, including pregnancy history, diet history, and other aspects of life. There were 203 women enrolled in the study, ranging in age from 30 to 88 years old, with the average age of 51. According to the information we collected during the interview, all major Alaska Native ethnic groups and geographic regions were included in the study. More than half (52%) of participating women listed Anchorage as the primary location for receiving health care. Of the 203 women, 190 (94%) reported being pregnant at least once, with an average age of 21 years old at the time of first birth. Of these 190 women, 183 (96%) had an average of four children each. Seventy-one percent (71%) of these 183 women reported breast feeding each child for at least 1 month and breast fed each child an average of 25 months. During interviews, participants were asked about a list of ten Native foods known to be consumed by Alaska Natives throughout the state. Participants were asked to report what foods were consumed at three points in their lives - at ages 10, 20, and 40. In general, study participants reported eating the same amount or somewhat less of the selected Native foods as they got older. There was no difference in levels of PCBs, DDT, and DDE among women with breast cancer compared to women without the disease. The Native diet is nutritious, especially eating younger fish and mammals, since they have lower levels of PCBs, DDT, and DDE.

Expected Outcome: The project will enhance primary prevention of breast cancer by evaluating the environmental risk factors for this disease. Findings from this study will be published in peer reviewed scientific journals.

Cancer Incidence and Mortality/Cancer Burden

Objective: To provide national data on the burden of cancer among AI/AN populations.

Background: Because of misclassification of AI/AN cancer patients as non-Natives in medical records, the cancer incidence data for AI/ANs have not been reliable.

Activities: Cancer cases diagnosed from 1995 through 2004 for the NPCR and SEER cancer registries were linked with administration records from the IHS. This linkage helps to avert racial misclassification.

Expected Outcomes: All NPCR registries have linked their data with IHS patient registration files to decrease race misclassification for AI/AN cases. The linked data will be used for a monograph focusing on AI/ANs as well as the 2007 Annual Report to the Nation on the Status of Cancer. These publications will provide the most comprehensive and reliable assessment of the burden of cancer among the AI/AN population, and would be useful for guiding cancer control activities in this population.

- **Environmental Health**

Alaska Native Maternal Organics Monitoring Study (MOMS)

Objective: Arctic research program focused on improving public health in Arctic communities by studying human exposure to environmental pollutants.

Background: Persistent organic pollutants (POPs), such as organochlorine pesticides and polychlorinated biphenyls, and heavy metals produced in the lower 48 states and other sub Arctic regions have been transported to Arctic regions, contaminating the Arctic food supply. Alaska Natives who rely on traditional diets of fish and marine mammals are exposed to higher levels of pollutants than are people living in the southern latitudes. Although health effects from occupational exposures to high doses of POPs have been documented, the developmental and health effects from long-term exposure to low levels of POPs, such as those found in wild animals eaten for food, require further study. Growing fetuses and infants may be particularly sensitive to POPs and other toxic contaminants in the food supply. A fetus or child may be exposed to several of these contaminants in utero or through breast milk; thus, the child's exposure depends largely on the levels present in the mother.

Activities: Study involves collecting serum and urine samples from mothers during one prenatal visit, and umbilical cord blood samples at delivery from Alaska Natives. Samples are analyzed for persistent organic pollutants, non-persistent pesticides, and trace metals, as well as for various nutritional markers. Pregnant women are enrolled at the Yukon-Kuskokwim Delta Regional Hospital in Bethel in collaboration with the Yukon-Kuskokwim Health Corporation Delta and in communities in the Aleutian and Pribiloff Islands in collaboration with the Aleutian-Pribiloff Island Association.
Preliminary results from MOMS suggests that lead concentrations in Bethel are two times higher than in Northern Alaska (e.g., Barrow, AK), an area where steel shot is the predominant form of ammunition used for hunting animals, waterfowl in particular, which make up part of the Native subsistence diet. A study was conducted to identify whether lead-shot used for hunting is a source of lead exposure in Alaska Natives. A cross-sectional exposure assessment study utilized isotope ratio (IR) methodology to compare the isotopic profiles of: 1) blood lead in Alaska Native women of Bethel and Barrow; 2) lead-shot samples from Bethel and Barrow; and 3) lead mineral and ore from a large smelter in Torreon, Mexico, implicated as the source of the lead in the shot. The lead IRs for blood samples from Torreon, Mexico, are significantly different from blood samples of residents in Bethel ($p = 0.023$) and Barrow ($p < 0.001$), implicating different sources of lead exposure in the two samples.

Expected outcome: Enrollment into the study will be completed in early 2007. An additional 200 women will be enrolled, and their samples sent to the NCEH Division of Laboratory Sciences for analysis.

- **Heart Disease and Stroke Prevention**

Objective: Reduce the time to treatment for myocardial infarction (MI) for rural AI/AN communities.

Background: Data from the National MI Registry show that the greatest disparity for time to treatment exists among racial ethnic groups and the AI/AN group has the longest delay times. The NATIVE study shows that rural American Indians presenting with acute MI have marked delays in time to treatment (12% of patients waited between 12–24 hours and 23% waited more than 24 hours to present) thus, limiting treatment options; the primary cause of the delay was due to patient misunderstandings about the symptoms of MI.

Activities: Monthly meetings are held with an advisory workgroup consisting of tribal persons, one WISEWOMAN project coordinator (Alaska), two Heart Disease and Stroke Program Coordinators (Montana, Alaska), and CVD HP2010 Partners, including American Heart Association, Indian Health Service, and National Heart Lung and Blood Institute. The advisory group is currently working to formulate questions interview and focus group questions.

Expected Outcomes: To gain an understanding of the barriers that impact AI/AN populations understanding of MI signs and the delays in treatment following an MI; to develop culturally tailored messages that customize the "Act in Time" national campaign; identify methods and style of delivery for the messages; identify innovate intervention strategies; pilot the messages with MI patients and their families in the Native American Cardiology Program.

- **Infectious Diseases in Alaska Natives Monitoring Infectious Disease Trends**

Objective: To describe the burden and trends of overall and specific infectious disease morbidity (hospitalizations and/or outpatient visits) among AI/AN populations using data from the IHS/tribal health care system, and to examine overall and specific infectious disease morbidity and health disparities among AI/AN populations as compared to the general U.S. population. Specific diseases are examined by appropriate age groups to describe the occurrence with those ages.

Background: Significant health disparities have been identified among the AI/AN population as compared to the general U.S. population. Further information is needed to assist in determining areas where prevention efforts would be most beneficial. Infectious disease has incurred excessive mortality and morbidity among AI/AN populations compared to the general U.S. population. For many specific infectious diseases, the occurrence and rate are not known or have not been recently studied within the AI/AN populations.

Activities: The projects are ongoing collaborative efforts between the Indian Health Service, Alaska Native Consortium, the CDC Arctic Investigation Program, and other agencies or CDC divisions to address the objectives of the studies. Hospital discharge and/or outpatient visit data and population data for AI/ANs were obtained from the Indian Health Service National Reporting System. Data are analyzed to describe the occurrence and rate of infectious disease hospitalizations and/or outpatient visits overall and for specific infectious diseases. Studies focus on overall and specific infectious diseases, for example, Rocky Mountain spotted fever, respiratory diseases, and diarrheal diseases.

Expected Outcomes: Gain a better understanding of the occurrence and rate of overall and specific infectious diseases among AI/AN populations, and identify geographic areas and demographic groups at high risk. The study findings will provide health information to assist in developing prevention strategies and reducing health disparities among AI/AN populations in the areas of infectious diseases. Disseminate study results through publications in peer reviewed journals, presentations at professional conferences, Indian Health Service Reports, Indian Health Service Provider newsletters, as appropriate.

Viral etiologies of respiratory hospitalizations in Alaska Native children

Objective: The projects are a collaborative effort between the Alaska Native Consortium, Artic Investigation Program, Indian Health Service, and CDC/NCZVED/DVRD to address the analytic objectives of the study. The study objectives consist of: 1)To conduct active surveillance for viral etiologies of LRTI in the Yukon Kuskokwim (YK) Delta of Alaska among children less than three years of age; 2) to determine the relative burden and seasonality of RSV infections using sensitive and specific RNA detection methods; 3) to determine the sensitivity and specificity of current antigen-based RSV tests as compared with RNA detection methods; and 4) to determine whether children with more than one RSV hospitalization in the same season have the same or different RSV strain.

Background: Lower respiratory tract infections (LRTIs) account for approximately 50% and 75% of hospitalizations among U.S. infants and AI/AN infants (<1 year of age), respectively. Respiratory syncytial virus (RSV) is the major cause of LRTI in infants and the highest published RSV hospitalization rate was reported in Alaska Native infants from Alaska's Yukon Kuskokwim (YK) Delta (rate of 156:1,000 infants; 1993–1996 data from active lab surveillance). Passive surveillance conducted in the Yukon Kuskokwim Delta since 1996 has shown a decrease in RSV from 178 per 1,000 infants/year to 104 per 1,000 but the overall hospitalization rage for LRTI remained stable at 284 per 1,000 infants from 1994–2004.

Activities: The study is conducted by the CDC Artic Investigations Program (AIP) and the Alaska Native Tribal Health Consortium (ANTHC) with collaboration from CDC's Division of Viral and Rickettsial Diseases (DVRD). The study activities consist of obtaining nasopharyngeal swabs for PCR evaluation for all children <3 years of age hospitalized at the YK Delta Regional Hospital for LRTI (informed consent is obtained prior to testing). Patient charts and radiographs will also be reviewed. Swabs will be sent to CDC-AIP laboratories for RT-PCR test for RSV, influenza A and B viruses, parainfluenza viruses I and III, corona virus, rhino virus and metapneumovirus. Sequencing of the RSV G gene will be performed by one of the collaborating laboratories for repeat RSV hospitalizations during the same season. Nasopharyngeal specimens for viral diagnostic testing will be collected on a comparison group of healthy children of similar age.

Expected Outcomes: Rates of LRTI and RSV hospitalizations will be calculated and analysis of demographic variables, receipt of RSV prophylaxis, and severity of disease will be conducted. The impact of viral load of each virus will be studied with respect to several variables. Quantitative RSV data will be used to assess the validity of rapid diagnostic tests. A case-control study will be conducted to evaluate factors associated with hospitalization. Information on viral etiologies of LRTIs will help determine the potential benefit of current and future interventions to prevent hospitalizations due to these infections.

- **Rabies Control, Navajo Nation**

Objectives: To examine the ability to reach feral dogs for rabies vaccination within the Navajo Nation; to test the differences in oral baits used to administer the rabies vaccination; and to successfully reach most feral dogs with the oral bait vaccination technique.

Background: The majority of yearly reported rabies cases in this area are due to canines, and roaming packs of feral dogs exist on land belonging to the Navajo Nation. Oral baits have previously been used to vaccinate feral dogs with success.

Activities: Offer free rabies canine vaccinations and limited serology testing through a clinic in the Navajo Nation during the month of April (continuation of annual project that began in 2003).

Expected Outcomes: Through the evaluation of different oral baits for the vaccination of canines, calculate the approximate total number of dogs that were successfully vaccinated and determine the most appropriate means for vaccinating feral dogs in this setting.

- **REACH 2010 Risk Factor Survey**

Objective: Continued collection and use of the REACH 2010 Risk Factor Survey

Background: CDC has conducted the annual REACH 2010 Risk Factor Survey in 27 minority communities since 2001.

Activities: The questionnaire included questions related to health status, health-care access, self-reported height and weight, cigarette smoking, awareness of hypertension, cholesterol, and cardiovascular disease, diabetes and diabetes care, and receipt of preventive services, such as mammography, Papanicolaou (Pap) smear, and influenza and pneumococcal vaccination. American Indian communities that were included in this survey were: Oklahoma (via telephone interview) and Eastern Band of Cherokee in North Carolina (via person-to-person interview).

Expected Outcomes: Data will be available on the above activities and used with and for the REACH projects.

- **Rocky Mountain Spotted Fever (Evaluation), Arizona**

Objectives: Determine the prevalence of *R. rickettsii* and identify the quantity, species, and stage of ticks present on the dogs at the time of blood sampling; determine if other sites near that of the study were at risk for cases of RMSF Arizona counties: Apache, Coconino, Gila, Graham, Greenlee, Navajo, and Pinal.

Background: The primary vector of Rocky Mountain spotted fever (RMSF) in the western United States is *Dermacentor andersoni*, whose range extends into northern and eastern Arizona. From 1981–2000, only 3 cases of RMSF were reported from the entire state. In 2004, during an investigation of an outbreak of Rocky Mountain spotted fever in communities within a region of east-central Arizona, *D. andersoni* ticks were not detected. Instead, the investigation identified *Rhipicephalus sanguineus* as the vector responsible for transmission of *Rickettsia rickettsii* (1). This tick has not been previously associated with transmission of RMSF to humans in the United States. Although *R. sanguineus* preferentially feeds on dogs, very large numbers of *R. sanguineus* found on dogs and in the peridomestic environments of this community appear to have facilitated the transmission of *R. rickettsii* to humans. A seroprevalence survey in dogs from the communities was undertaken in 2004, and 70% of dogs sampled were positive by IFA for antibodies to *R. rickettsii*. Interestingly, sera collected in 1996 from dogs in this same area had yielded a prevalence of 5%, indicating that the rate of *R. rickettsii* infections had increased in the tick population of this area.

Activities: Ten sites in seven counties participated by randomly enrolling dogs that were housed in animal shelters, and serum samples were obtained and ticks were collected from 265 dogs. Serum was tested for IgG antibodies to *R. rickettsii* and dogs were examined for the presence of *R. sanguineus* ticks as well as *Dermacentor andersoni*

Expected Outcomes: Using a minimal threshold of 1/32, seroprevalence by county will be calculated and the level of tick infestation on sampled dogs will be determined.

- **Rocky Mountain Spotted Fever (Proposal for Control), Arizona**

Objectives: To assess and reduce the risk of RMSF among inhabitants of reservations in Arizona, we are proposing the development and implementation of a comprehensive program for education, reservoir and vector control, and surveillance. These activities should have considerable impact in increasing awareness of the risk and dramatically reducing peridomestic populations of *R. sanguineus* ticks. The program will be piloted within five reservations. An integrated effort will include surveillance at local clinics and hospitals; physician and medical staff awareness for early diagnosis and initiation of treatment; community-based education to increase awareness of RMSF risk; coordinated peridomestic clean-up campaign to

decrease suitable tick habitat; treatment of infested home environments with effective acaricides; treatment of dogs with effective acaricides; and development of an animal control program to address stray dog issues.

Background: RMSF, caused by *Rickettsia rickettsii*, is a severe and sometimes fatal disease transmitted to humans via ticks. Starting in 2003, an unusually high rate of RMSF cases was reported in a region of eastern Arizona encompassing 2 American Indian reservations. Since 2002, there have been 24 cases of RMSF, primarily among children less than 12 years of age. The average annual incidences of pediatric RMSF in this region ranges from 8.9 to 12.7 cases per 100,000 persons, which is over 500 times higher than the average annual incidence of this disease in children in the United States. The economic and emotional burden of these cases is high, with 13 cases having an illness severe enough to require hospitalization, 6 cases developing life-threatening illness severe enough to require intensive care or medical evacuation, and 2 cases having fatal outcome (both young children). Populations of *R. sanguineus* ticks, a vector for *Rickettsia rickettsii*, may be extremely numerous on other reservations. RMSF cases may also be occurring, but not recognized due to lack of awareness by physicians and the local population. Risk assessments on other reservations in Arizona need to be conducted to identify potential risk for RMSF in order to apply appropriate prevention and control.

Activities: Planned activities include surveillance; physician and medical staff awareness; community education; community clean-up campaigns; treatment of infested home environments; treatment of dogs; development of an Animal Control Program:

Expected Outcomes: Active surveillance will be instituted at the local clinics and hospitals serving the reservations to identify cases of RMSF with a broad case definition of febrile illness of unknown origin. Patient records will be reviewed for the past two years using the case definition of fever and rash to identify possible cases of RMSF. Educational materials will be developed to include general information on RMSF and specific information regarding clinical signs and symptoms, diagnostic testing, and appropriate treatment regimens for adults and children. A program will be established to provide seminars for medical staffs either at individual health facilities or as part of a continuing education program. Collaborating partners will coordinate community clean-up campaigns specific for each reservation-targeting the removal of items ticks could inhabit. Efficacy of dry ice traps will be determined during dwelling clean up measures. Efficacy of the tick control on dogs and in the community will be assessed. An animal control program will developed early in the intervention process to ensure a timely reduction in stray dog numbers prior to treatment of infested homes.

- **SIDS and Fatty Acid Ethyl Esters**

Objective: To analyze the meconium samples collected for Fatty Acid Ethyl Esters (FAEE) in order to link alcohol usage during pregnancy in mothers who have lost children due to SIDS and stillbirth.

Background: Compelling epidemiologic, physiologic, and pathologic data now suggest that maternal drinking during pregnancy, SIDS, and stillbirth may be inter-related in important ways. The Prenatal Alcohol, SIDS, and Stillbirth (PASS) Research Network proposes here a community-linked prospective study to investigate the role of prenatal alcohol exposure in the risk for SIDS and stillbirth, as well as other adverse pregnancy outcomes, including fetal alcohol syndrome. This study will involve women from two areas plagued by high rates of perinatal mortality and prenatal alcohol exposure: American Indians in Northern Plains and Cape Coloured (mixed race ethnicity) in South Africa. Data about the mother and infant will be collected during the prenatal period and through the infant's first year of life. Information on exposures during the prenatal period, fetal and physiological development, infant neurobehavioral measures, maternal and infant genetic factors, and placental tissue pathology will be collected.

Activities: CDC is awaiting the arrival of samples for analysis.

Expected outcome: Examine the inter-relationships between alcohol, SIDS, and stillbirth, and the influence of genetic and environmental interactions in the pathogenesis of a spectrum of adverse pregnancy outcomes related to maternal drinking.

- **Tobacco-Related Research**

American Indian and Alaska Native Adult Tobacco Surveys

Objective: The purpose of the American Indian Adult Tobacco Survey (AI ATS) is to collect tribal-specific data that will help determine tobacco use in specific tribes and guide the development of tribal-specific interventions. The AI ATS will facilitate the collection of tribal-specific tobacco-related data by providing a culturally competent tool that respects the culture and sovereignty of tribes and their villages.

Background: National surveys have shown the prevalence of smoking among the American Indians (AI) to be higher than 30%. Acknowledging the high prevalence of commercial tobacco use in specific AI tribes and the lack of tribal- specific data, CDC's Office on Smoking and Health (OSH) convened representatives from Tribal Support Centers, tribes, and the AI community to participate and advise OSH on survey development. The AI ATS was designed as both surveillance and evaluation tools to provide tribal-specific information regarding trends in tobacco use, cessation efforts, exposure to secondhand smoke, and tobacco-related knowledge and practices among adults 18 years of age and older who reside within their respective tribal community.

Activities: The AI ATS was first conducted in 2005 among 11 tribes by trained local tribal interviewers. The data collected are owned exclusively by the tribes or villages that participate in the surveys, not by states or the federal government. The 11 tribes that conducted the AI ATS, found that the face-to-face method was the most appropriate way to administer the survey within their communities, but that telephone interviews may also be conducted. Previous cognitive interviewing findings indicated that Alaska Natives were so culturally distinct from American Indians that a separate survey was needed for them. Further cognitive interviewing findings indicate that two distinct surveys were needed – one for rural Alaska Natives and one for urban Alaska Natives. Issues that informed this decision include differences in types of tobacco use; differences in average educational attainment; differences in world-views; differences in traditionalism and the like. As a result, OSH is currently developing both a Rural Alaska Native Adult Tobacco Survey and an Urban Alaska Native Adult Tobacco Survey. The Alaska Native Tribal Health Consortium is expected to field these surveys and it is anticipated that community-specific prevalence and use information will be generated. The findings will inform and improve community-specific programs and interventions.

Expected Outcomes: AI ATS will provide tribal-specific data that can be used to guide tribal tobacco control efforts. Data from the survey can be used to help direct culturally appropriate program planning, evaluate programs and develop policy; tailor interventions, allocate resources, obtain funding, and monitor industry marketing tactics for specific U.S. tribes.

Nicotine Exposure and Metabolism in Alaska Native Adults

Objective: Describe exposure to nicotine and carcinogens (tobacco-specific nitrosamines [TSNAs] and polycyclic aromatic hydrocarbons) in Alaska Native adults who smoke cigarettes, use commercial chew tobacco, or use a homemade mixture of chew tobacco and ash (Iqmik); characterize nicotine metabolism in Alaska Native adult tobacco users by measuring plasma 3'-hydroxycotinine:cotinine ratio and by sequencing genes related to nicotine metabolism; and quantify the pH, free nicotine

content, and carcinogen (TSNA) content in commercial chew and Iqmik.

Background: The prevalence of cigarette smoking in AI/AN is 40.4 percent; the highest of any group in the United States. The prevalence of cigarette smoking in AN 43%, compared with 23% in the general U.S. population. The prevalence of smokeless tobacco use is 14% among AN adults versus 4% in the total U.S. population.

Activities: CDC will provide urinary nicotine metabolite profiles (including cotinine) on all tobacco users in the study; other collaborators at UCSF are conducting the other biomarker analyses in the study.

Expected Outcomes: CDC's laboratory results will be part of the overall analysis of this study to fully understand nicotine and carcinogen exposure among Alaska Native individuals who use various tobacco products. Comparisons will be able to be made between product types which ultimately can guide cessation efforts.

Smoking Cessation in Alaska Native Women Study

Objective: Increase smoking cessation among Alaska Native women.

Background: Alaska Natives have the highest smoking rate during pregnancy of any ethnic group. Alaska Native leaders are aware of this problem and they are committed to changing it. This study is a planned intensive smoking cessation effort to be undertaken as part of the Smoke-Free Families initiative to stop smoking during and beyond pregnancy. This study will involve approximately 500 women who will be evaluated and counseled at their first prenatal visit, and again at the 6^{th} and 8^{th} month of pregnancy. Previous studies of smoking cessation during pregnancy have confirmed that biomarkers, such as cotinine measurements, are essential for accurate assessment of the results.

Activities: CDC will provide analyses of biomarkers to ensure accurate assessment of study results. These data will also provide needed new information on the extent of exposure, based on biomarker analysis, in this population. During FY 2005, we completed an initial pilot study of this project. During FY 2007, we will provide analyses for the fuller study. This will include measuring salivary cotinine in women and children; women will have three measurements taken during pregnancy, and both the mother and infant will have 5 measurements taken during the first year of the infant's life.

Expected Outcome: Identification of facilitators and barriers to smoking cessation among Alaska Native women.

Smokeless Tobacco Use by Alaska Natives

Objective: To study the health effects of iq'mik, a form of smokeless tobacco used by Alaska Natives.

Background: Alaska natives in specific remote locations use a form of smokeless tobacco called iq'mik. This is a combination of tobacco and punk tree ash. The punk tree ash is likely used to increase nicotine bioavailability by altering the pH of the material. Iq'mik is widely provided to infants to lessen the pain from teething and used by pregnant women as an alternative to smoking. Both of these uses pose an increased risk of disease in a population that may not have been well educated concerning the risks.

Activities: CDC is working with Alaska Native groups to develop information on the product and its effects in people that can then be used in educating AN communities about the threats of adverse effects from the use of iq'mik. During FY 2006, CDC completed plans and implemented protocols for this study; CDC also obtained iq'mik samples and has begun to assess levels of toxic and addictive compounds in these samples. The study will continue through FY 2007.

Expected Outcome: Increased scientific understanding of the harms of iq'mik use and enhanced awareness of risk among Alaska Native people.

- **STD Prevention and Control**

Objective: To improve the relevance of national STD surveillance data for Indian country.

Background: The IHS system of records provides a rich source of health data for approximately 56% of the total U.S. AI/AN population. IHS health data primarily focus on population statistics, birth/death data, and patient care utilization. Data on STDs and other nationally notifiable diseases are lacking, yet these diseases represent a significant burden on healthcare systems in Indian country. STD surveillance data reported to CDC are typically available only at the county, state, or national levels. IHS and tribal administrative areas, however, are made up of groupings of select counties from select states. New approaches and methodologies are needed to better manage and analyze federal data sources that support public health programs in Indian country.

Activities: CDC and IHS National STD Program staff collaborated with statisticians from both agencies to improve AI/AN STD surveillance methodology, whereby CDC's nationally compiled STD data are coded and presented using population parameters based on IHS and tribal administrative regions (Areas and Service Units). A final report focusing on chlamydia, gonorrhea, and syphilis was published in early FY 2007 and will be distributed broadly to public health programs in Indian country.

Expected Outcomes: This approach to analysis of surveillance data will improve the accuracy of STD epidemiologic data for AI/ANs, and may serve as a model for addressing similar issues for other reportable diseases, such as hepatitis and tuberculosis.

West Nile Virus (WNV)

Objective: As part of overall efforts to monitor WNV and other insect transmitted diseases (arboviruses), monitor trends in WNV among AI/AN populations.

Background: In 2006, there were 50 reported cases of WNV infection and 1 reported case of LaCrosse encephalitis for whom the race of the case was reported to be American Indian/Alaskan Native. Fourteen of these WNV cases were reported to be neuroinvasive (meningitis or encephalitis), 31 were uncomplicated fever, and 5 were unknown/other clinical presentation. These WNV cases represent 1.3% of total reported WNV cases in 2006 (as of 10/31) and 1.1% of the WNV neuroinvasive cases in 2006. West Nile Virus cases among Native Americans came from 11 states, Arizona, California, Colorado, Montana, North Dakota, New Mexico, Nevada, South Dakota, Utah, Wyoming, and the LAC case was from North Carolina. Of note, only about 70% of the arboviral infections reported to CDC include information on the case's race.

Activities: CDC developed an electronic-based surveillance and reporting system (ArboNet) to track WNV activity in humans, horses, other mammals, birds and mosquitoes. ArboNet surveillance system has been used to streamline reporting to CDC of WNV activity by the state public health departments.

Expected Outcomes: Provide ongoing information about trends in WNV and other arboviral diseases among AI/AN populations.

Health Resources and Services Administration (HRSA)

PRIORITY: **Health Professions Recruitment**

Objective: To expand and increase awareness of the requirements and opportunities for health professions training among American Indian Alaska Native youths.

Background: For a number of years the Association of American Indian Physicians (AAIP) has supported a summer activity of bringing approximately 75-80 American Indian Alaska Native high school students interested in pursuing health professions education to Washington, DC. This program is known as the National Native American Youth Initiative

(NNAYI). Through its cooperative agreement with the Office of Minority Health, NNAYI program is an intense academic enrichment and reinforcement program designed to better prepare students to remain in the academic pipeline and pursue a career in the health professions and/or biomedical research. Each year, the agenda consists of visits to the various DHHS entities, e.g., NIH, IHS, FDA, CDC, SAMSHA and HRSA. One of the staff members in HRSA's MCHB has annually participated in this program to represent the Nursing Profession to these students. The need for increased minority professionals is paramount particularly at a time when there are critical shortages across the board in the health professions. By increasing the awareness of the requirements and opportunities for health professions training, particularly from those who are American Indian health professionals, it is likely to result in these students pursing careers in the health professions.

Activities:

Activity 1: HRSA will continue to participate in the presentations along with other American Indian health professionals in IHS/SAMSHA/FDA/NIH/OMH/HRSA to these students on an annual basis. There has been no monetary cost to provide a 45 minute presentation in the Parklawn Building Conference Room area.

Expected Outcomes: The outcome is increased interest in the nursing profession by NNAYI visiting students. Based on the discussion during the Q and A session there is always considerable interest in knowing more about what the profession of Nursing is all about, particularly the various types of nursing education programs.

Divisions and Other Groups Involved in Addressing Priority: IHS, FDA, SAMHSA, OMH, NIH

***PRIORITY*: Emergency Preparedness**

Objective: To ensure increased access to emergency medical services for children (EMSC) resources aimed at underserved populations, including AI/ANs.

Background: EMSC grants fund States and U.S. Territories to improve existing emergency medical services (EMS) systems and to develop and evaluate improved procedures and protocols for treating children. The EMSC program is the only Federal program that focuses specifically on improving the quality of children's emergency care. All States, U.S. Territories and the District of Columbia have received Federal funding. Currently, only State governments and accredited schools of medicine are eligible to receive EMSC grants. State Partnership grants solidify the integration of a pediatric focus within the State EMS system, the only eligible applicant is the State EMS agency, unless the State specifically requests and designates another State entity. States receive as much as $115,000 per year, for as many as 3 years. In addition, the EMSC Program has an interagency agreement with the Indian Health Service to promote relationships between Tribal/HIS Emergency Medical Service (EMS) programs and State EMS Programs; strengthen the infrastructure within the Native American EMS Association as related to pediatric EMS issues; and coordination of training, education, and skill development of pre-hospital personnel regarding pediatric assessment, stabilization, resuscitation, and disaster preparedness through the Mountain Plains Health Consortium and other avenues

Activities:

Activity 1: Emergency Medical Services for Children (EMSC) funded three State Partnership grant initiatives aimed at AI/AN populations in FY2006. These grants were begun in Alaska, Hawaii, and South Dakota. Each State receives a partnership grant of $115,000 of which 10 percent or approximately $15,000 is spent on AI/AN populations totaling $45,000.

A. <u>Alaska</u> The EMSC State Partnership grant initiatives in Alaska impacts the Native Alaskan population. The focus of the initiatives is to improve the delivery of

pediatric emergency care by implementing the new EMSC performance measures.

B. Hawaii The EMSC State Partnership grant initiatives in Hawaii impacts the Native Hawaiian population. The focus of the initiatives is to improve the delivery of pediatric emergency care by implementing the new EMSC performance measures.

C. South Dakota The South Dakota EMSC (SD EMSC) State Partnership grantee works closely with the state's Native American population. The following is an example of an initiative directed at this population.

- Bystander First Aid and Injury Prevention courses have been implemented on Pine Ridge, Lower Brule, Crow Creek and Cheyenne River reservations with Instructor classes held at each location for EMS providers, Head Start workers and Community Health Representatives. The course was developed to include culturally specific slides and topics.

Activity 2: Through an Interagency Agreement (IAA) between HRSA's EMSC Program and the Indian Health Service/Division of Environmental Health Services for $250,000 in FY06. The focus of this agreement is to provide for collaborative activities between EMSC and HIS and increase access to EMSC resources for underserved populations, including AI/AN populations. A large portion of these funds will go toward pediatric specific training for pre-hospital providers within tribal health and Indian Health Service.

Expected Outcomes: EMSC State Partnership grants are focused on meeting the following performance measures:

1. Ensure operational capacity to provide pediatric emergency care by guaranteeing pre-hospital provider agencies have on-line and off-line pediatric medical direction; pre-hospital providers agencies have essential pediatric equipment and supplies; implement a state-wide, territorial, or regional facility recognition program for hospitals that are able to stabilize and/or manage pediatric emergencies; and hospitals have written inter-facility transfer guidelines and agreements that specify alternate sites that have the capabilities to meet the clinical needs of critically ill and injured pediatric patients.
2. Adopt requirements by states/territories for pediatric emergency education for the recertification of paramedics.
3. Establish permanence of EMSC in each state/territory

EMSC interagency agreement is focused on:

1. Increasing access to EMSC resources for underserved populations including American Indian/Alaska Native populations, and
2. Providing pediatric-specific training for pre-hospital providers within tribal health and Indian Health Service

Divisions and Other Groups Involved in Addressing Priority: IHS

Objective: Health centers play an important role in delivering critical services and assisting local communities during an emergency. To do so, they must be adequately prepared to deal with emergencies and should be fully integrated into the local emergency planning and response. To assist in the provision of information on the need for emergency preparedness by Alaskan Natives and Native Americans

Background: BPHC encourages health centers to develop and implement an emergency management plan, develop effective communications networks, collaborate with Federal, State, and local organizations, provide data reporting to the extent possible, and make considerations for maintaining financial stability during and after an emergency.

Activities:

Activity 1: A Policy Implementation Notice will be forthcoming informing the community health centers including the tribal entities and

Title V Urban Indian grantees on how to develop and implement an emergency management plan and develop linkages with other organizations.

Activity 2: Each grant application requires an emergency management plan as part of the Section 330 requirements.

Activity 3: The BPHC staff attended Tribal Consultation Meetings in Spring of 2006 and participated in discussions of areas to consider in emergency planning. Pandemic Flu was also discussed at this meeting.

Expected Outcomes: The community health centers will have implemented an emergency management plan in their communities with data reporting tools to assess damage and make considerations for maintaining financial stability during and after an emergency.

Divisions and Other Groups Involved in Addressing Priority: HRSA Grantees, Primary Care Associations, NIH, CDC

Objective: Increase the number of organ and tissue donors and number of actual donations within the Native American population involved in the study and in those groups reached by the study participants.,.

Background: This complements existing initiatives to increase awareness of the need for organ donors in all minority populations, especially in the African American and Native American populations where there are high numbers of people with hypertension and diabetes, and the resulting kidney damage that often requires a kidney transplant.

Activities:

Activity 1: The study supported by HRSA is entitled, *Sharing the Gift of Life: A Multi-state American Indian Tribal College Intervention to Increase Organ and Tissue Donation* and is a multi-state, culturally-targeted intervention utilizing the Native-American tradition of story-telling and gift giving among the Plains tribes will be delivered to tribal colleges in the US Great Plains to address the need for kidney transplantation and the corresponding low donation consent rate. The intervention incorporates print, video, and web site materials. Outcomes measures include improved readiness to be an organ donor, the move to action, and family notification.

It includes the 3,000 college-age students from the Plains Tribes at six Tribal Colleges and Universities including Salish Kootenai College, Sinte Gleska University, Sitting Bull College, Oglala Lakota College, Chief Dull Knife College, and Leech Lake Tribal College.

Expected Outcomes: The project will increase awareness of the need for organ donors in this population and also the number of potential and actual donors. The effect of this educational intervention will be assessed by measuring the readiness to sign a donor card, the number of donor cards signed, and by the number of discussions with family members about the decision to be an organ donor.

Divisions and Other Groups Involved in Addressing Priority: None

***PRIORITY*: Health Care Access**

Objective: To strengthen the operations of existing health centers and I/T/U Indian Program organizations.

Background: Since tribes have identified diabetes, cancer, and cardio-vascular disease as specific concerns, the Bureau of Primary Health Care (BPHC) is addressing health disparities for Indian people through its primary care programs. In October 2004, a Health Disparities workgroup was formed with HRSA and IHS to expand access to quality primary and preventive health care and to strengthen the operations of existing health centers and I/T/U Indian Program organizations. This is an ongoing process.

The Health Disparities workgroup began with the most immediate goal of expanding access by increasing the number and quality of applications for 330 funding from I/T/U organizations. Another area the workgroup

focused on was sharing best practices in the area of clinical quality. HRSA and IHS collaborated on lessons learned from Electronic Health Record (EHR) implementation as well as sharing best practices from the nationally recognized work of the HRSA Health Disparities Collaboratives, particularly those participating health centers caring for more than 20 percent Native American populations having experienced decreases in health disparities.

Activities:

Activity 1: Ensure that increased numbers of health center teams are working with AI/ANs in various collaboratives.

Activity 2: Continue to strengthen the health outcomes of AI/ANs populations through various collaboratives.

Activity 3: Provide increased technical assistance to tribes.

Expected Outcomes: The health outcomes of AI/ANs will continue to improve and these improvements will be sustained over time.

Divisions and Other Groups Involved in Addressing Priority: Primary Care Associations and IHS

Objective: To ensure that the needs of AI/ANs continue to be addressed.

Background: HRSA's HIV/AIDS Bureau (HAB) and IHS have long been collaborating on improving services for AI/AN populations. Several programs have been implemented which target AI/AN HIV care and treatment, provider training through the AIDS Education and Training Centers (AETCs), and innovative models of care through the Special Projects of National Significance (SPNS) program. AI/AN population represent 0.7% of all the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Clients.

The CARE Act has made great strides in servicing this population and developed and distributed a policy (Policy Notice 00-01: The Use of Ryan White CARE Act Funds for American Indians and Alaska Natives and Indian Health Service Programs, 2000) to encourage AI/AN access to the CARE Act and related HIV specialty services. This policy was reissued in 2003 with a companion Question and Answer guide. Although the numbers of AI/ANs affected by HIV/AIDS seem low in comparison to other ethnic groups, these numbers may not be accurate and reflective of the actual numbers of AI/ANs with HIV/AIDS as many present for HIV care later in the disease progression, are often misclassified into other racial/ethnic groups, and are under reported by tribal groups. Consequently, the need to reach, test, diagnose, and deliver HIV services still exists. HRSA and IHS have been making efforts to meet this need.

The HIV/AIDS Workgroup has completed a needs assessment of current grantees that provide services and training to AI/AN providers and clients affected by HIV/AIDS. A formal means of disseminating information to AI/AN providers, grantees, tribal groups, and other community organizations providing services to Native Americans is being developed in collaboration with IHS to further market CARE Act programs, encourage CARE Act Titles to contract and subcontract with these groups, and improve AI/AN representation on Title I planning councils.

Activities:

Activity 1: Reduce health disparities in chronic diseases such as HIV/AIDS and other conditions.

Activity 2: Increase the supply of health professionals available to provide health care in Indian country and other underserved areas.

Activity 3: Reduce the burden of HIV/AIDS in the Indian people and other populations.

Expected Outcomes: In FY 2006, continue to increase the number of AI/ANs who are aware of their HIV status and as a result, enter into care.

Divisions and Other Groups Involved in Addressing Priority: IHS

***PRIORITY*: Health Promotion Disease Prevention**

Objective: To prevent early childhood caries in a very high-risk population of American Indian/Alaskan Native (AI/AN) children using Chlorhexidine Varnish. Since the major reservoir from which infants acquire mutant streptococci (MS), the primary etiologic agent causing early childhood caries (ECC), is their mother or primary caregiver, mothers of young infants are recruited for the study.

Background: In the U.S., the population group with one of the highest rates of Early Childhood Caries (ECC) is AI/AN. Nationwide, approximately 76 percent of AI/AN two – four year olds have decay, compared to 18% of non–AI/ ANs in the same age group. This study addresses the MCHB Strategic Research Issues to address health disparities and barriers to health care access and to promote the healthy development of maternal and child health (MCH) populations. The research project is a 4-year project with funding of $1.2 million over 4 years.

Activities:

Activity 1: HRSA supports a randomized, double-blind, placebo-controlled clinical trial designed to test the efficacy of a 10 percent chlorhexidine varnish for the prevention of early childhood caries in a very high risk population of AI/AN children.

Expected Outcomes: If successful, this study could pave the way for an effective new primary prevention modality for ECC using chlorhexidine varnish applied to mothers' teeth.

Divisions and Other Groups Involved in Addressing Priority: None

Objective: To reduce infant mortality rates, prematurity, low birth weight, and increase access to prenatal care for the Wisconsin Native American tribal communities.

Background: Healthy Start Project : The Great Lakes Inter-tribal Council of Wisconsin's Honoring Our Children Healthy Start Project (HOC) grantee includes 7 tribal entities working together to reduce rates for infant mortality, prematurity, low birth weight and access to prenatal care.

As the result of a statewide conference organized in 2003 to address the disparities among racial and ethnic groups in Wisconsin, the Wisconsin Native American tribal communities formed a workgroup as part of "Healthy Babies in Wisconsin: A Call to Action." The workgroup used the results from a Perinatal Periods of Risk analysis of the Wisconsin fetal and infant mortality data to determine that the highest risks for Native Americans were in the infant health and maternal care categories. The priorities for action included smoking cessation, breastfeeding promotion and support and addressing social issues.

In November 2004 and 2005, the HOC staff members and the Native American Workgroup met again as part of the 12th and 13th Annual Healing Our Communities Conference, to share best practices in the priority areas and build upon the action plans.

During the latest reporting period (6/1/05-5/31/05), the HOC central staff worked to increase prenatal care coordination and billing for nursing services through the tribes. Collaboration with the state and HRSA's MCH Title V program has resulted in tribal MCH/HOC nurse trainings to make billing easier for the tribes.

Activities:

Activity 1: The HOC staff also participated in the following HRSA sponsored meetings which provided technical assistance opportunities: the 2006 Healthy Start Grantee Meeting in June 2006 and the National Healthy Start Association's 2006 Midwest Regional Conference in May 2006.

Expected Outcomes: Reduction in the infant mortality rates, prematurity, low birth weight, and increased access to prenatal care for the Wisconsin Native American tribal communities.

Divisions and Other Groups Involved in Addressing Priority: None

***PRIORITY*: Tribal Consultation**

Objective: To assist in development of strategies to obtain 330 funding to develop AI/NA health centers.

Background: The Tribal Consultation group began by holding meetings with interested Tribes to provide technical assistance to equip them in applying for Federal Section 330 funds in the event that Federal funds to IHS was not available and Section 330 funds become available. The group discussed Section 330 funding opportunities. HRSA staff provided information and clarification regarding reimbursement policy interpretation for Tribes with section 330 funding and other issues.

Activities:

Activity 1: HRSA assisted in development of strategies to obtain 330 funding to develop AI/NA health centers. HRSA also met in Washington, D.C. with several Tribes that were interested in applying for funds.

Activity 2: HRSA staff provided information and clarification regarding reimbursement policy interpretation for tribes with Section 330 funding and similarly clarified meeting with the Montana Primary Care Association and tribal representatives interested in applying for Section 330 funding opportunities.

Activity 3: HRSA participated in numerous technical assistance and training activities that were attended by tribal organizations including responding to numerous request for additional information on HRSA programs, requirements, and expectations as well as National Application pre-conference calls and various training events by National and State organizations. Staff also participated in an on-site visit to tribal groups to discuss the requirements for the Health Center Program.

Expected Outcomes: Level of funding and access to primary care for AI/AN will be increased and potential applications for community health center funding, planning, and development of primary medical care practices will continue to expand. Improved communication between HRSA and AI/NA that allows for identification of AI/NA health care needs for the improvement of health services to the AI/NA communities

Divisions and Other Groups Involved in Addressing Priority: Montana Primary Care Association, Various Tribal Organizations

***PRIORITY*: Increase Access to HHS Programs and Grants; Improve technical assistance for all AI/AN/NAs**

Objective: Provide a grant program that is available to minority populations and provide technical assistance workshops for the grantees at the pre-application and pre-implementation phases for the potential and new grantees. And once a year provide technical assistance workshops to all grantees. These workshops are given to strengthen the research effort including methodology, data collection, and evaluation process.

Background: This complements existing initiatives to increase awareness of the need for organ donors in all minority populations, especially in the African American and Native American populations where there are high numbers of people with hypertension and diabetes, and the resulting kidney damage that often requires a kidney transplant.

Activities:

Activity 1: The study involves 3,000 college age students from the Plains Tribes at six Tribal Colleges including Salish Kootenai College, Sinte Gleska University, Sitting Bull College, Oglala Lakota College, Chief Dull Knife College, and Leech Lake Tribal College.

The grant entitled, "*Sharing the Gift of Life: A Multi-state American Indian Tribal College Intervention to Increase Organ and Tissue Donation" is a* multi-state, culturally-targeted intervention utilizing the Native-American tradition of story-telling and gift giving among the Plains tribes will be delivered to tribal colleges in the US Great Plains to address the need for kidney transplantation and the corresponding low donation consent rate. The intervention incorporates print, video, and web site materials. Outcomes measures include improved readiness to be an organ donor, the move to action, and family

Expected Outcomes: The grant projects will benefit from the technical assistance workshops by providing stronger research results and more reliable information from the grant studies. The grant program has been in existence since 1999 and the grantees are developing a well-researched body of knowledge pertaining to issues surrounding organ and tissue donation, the lack thereof, and the barriers that contribute to the 18 deaths per day of patients who die while waiting for a transplant.

Divisions and Other Groups Involved in Addressing Priority: None

Objective: Office of Health Information Technology has Health Center Controlled Networks (HCCN) that provide support and advice to Community Health Centers in the several core areas such as administration and information technology which in turn help to increase effectiveness of human services. The HCCN grant supports Health Centers that provide services to Native American populations in New Mexico and Arizona.

Background: HCCN is an umbrella that includes the Integrated Services Development Initiative (ISDI). HCCN support the creation, development and operation of networks of the safety net providers to ensure access to health care of the medically underserved populations though the enhancement of health center operations. HCCN support Health Centers in decision making in improving administration, clinical care, managed care, finances and information systems.

Activities:

Activity 1: New Mexico Integrated Services Network (NMISN) has a grant that provides operational practice management and SIMIS network of six New Mexico Federally Qualified Health Centers (FQHCs). It is the six FQHCs supported by NMISN that provide clinical care to Native Americans. NMISN provides operational practice management to FQHCs in the following areas: Information Technology, finance, and clinical care.

Activity 2: Community Health Centers Collaborative Ventures, Inc promotes the collaboration and sharing of services and business initiatives among community health centers and to enhance their efficiency and effectiveness in the delivery of primary care services to BPHC Health Center target populations in Arizona of which 5 % are Native Americans. They have locations in fourteen of the fifteen counties in Arizona.

Expected Outcomes: NMISN is expected to improve hardware / software which will decrease the amount of information systems downtime. NMISN will improve billing and collection. Also they will help to improve patient satisfaction statistics and improve immunization compliance.

Community Health Centers Collaborative Ventures, Inc will have all twelve CHCs utilize a common financial reporting system and a common practice management system. All the CHCs will have pharmacies. There will be Human Resource integration and purchasing consolidation.

Divisions and Other Groups Involved in Addressing Priority: None

Objective: To provide technical assistance (TA) for all AI/AN.

Background: Providing technical assistance/consultation is based on recognized

existing expertise as well as trust and credibility from the entity being asked to provide the TA, particularly when dealing with the American Indian Alaska Native Tribes. This past year, TA was requested to provide peer review expertise for a new Public Health Nursing (PHN) Grant Program in the Indian Health Service along with general assistance/consultation with the entire expanding discretionary grant programs within the Agency.

Activities:

Activity 1: Provide peer reviewer assistance when requested to the HIS discretionary grant programs when requested.

Activity 2: Provide TA/consultation to the IHS on the discretionary grant process when requested.

Expected Outcomes: Completion of a peer reviewed process for a grant program. Provide TA to the discretionary grant programs in the IHS as requested.

Divisions and Other Groups Involved in Addressing Priority: None

Objective: To provide leadership and grant assistance to improve the supply and distribution of qualified basic and graduate nursing students and registered nurses to meet the health care needs of the nation.

Background: Indian Tribes and Tribal organizations are eligible entities capable of carrying out the legislative purposes authorized under Title VIII, the Nurse Reinvestment Act of 2002, Public Law 107-205 (amended by the Nursing Education and Practice Improvement Act of 1998 and Public Law 105-392.

Activities:

Activity 1: The Division of Nursing is redesigning its website to disseminate information about Division of Nursing program offerings for AI/AN/NAs. Program brochures were created to disseminate information about Division of Nursing program offerings for AI/AN/NA based organizations.

Activity 2: The Division of Nursing will offer group and individual technical assistance as requested during face-to-face office visits, external meetings, telephonic, or via teleconference consultations.

Activity 3: The Division of Nursing increased the number of nurses and nurse educators from American Indian backgrounds to serve as merit peer reviewers for all of the grant programs.

Activity 4: The Division of Nursing provides direct email invitations to the National Alaskan Native American Indian Nurses Association (NANAINA) 4-6 weeks before the annual Division of Nursing Technical Assistance Workshops.

Expected Outcomes:

1. There will be increased access to program information on the web site (number of site hits) and via printed brochures (number of program brochures disseminated).

2. There will be increased access to one-on-one technical assistance opportunities documented by program staff.

3. There will be increased numbers of applications for funding from entities that target the Native American/American Indian based applicant organizations.

4. There will be increased numbers of requests for technical assistance from Tribal Colleges and Universities during the 2008 application period.

5. There will be an added cultural perspective on the Division of Nursing review panels that enriched advice to applicants in the summary statement language related to recruitment and retention of American Indian nurses into

the programs, and collaboration with Tribal Colleges and Universities.

6. There is expected to be an increase in number of nursing education graduate programs that partner with and engage in outreach to TCUs and increase number of American Indian students in graduating from advanced practice and other graduate programs.

Divisions and Other Groups Involved in Addressing Priority: None

Objective: To ensure increased access to funding for new access points, service expansion initiatives, and expanded medical capacity serving AI/ANs. This is part of the President's FY 2006 Initiative.

Background: The FY 2006 President's Initiative provides funding for new access points, services expansion to existing health centers, and the expansion of medial services. This initiative is targeted to increasing access to primary care for medically underserved and high poverty areas.

Activities:

Activity 1: In FY 2006, community health centers in the States of Michigan, Minnesota, and New Mexico received over 1.7 million dollars of funding which will be utilized to add new sites, expand their present medical capacity, and add or expand medical services while serving an additional 27,000 new AI/AN patients.

Activity 2: The HRSA/BPHC will continuously perform the following:

Staff from the HRSA/BPHC will continue to participate in numerous technical assistance and training activities that are attended by tribal organizations. These include:

- Training events sponsored by the national and State organizations.
- National pre-application conference calls for all of the announced competitive opportunities to provide technical assistance on the requirements of the program and expectations for successful applicants.
- Responding to numerous requests for additional information on BPHC programs, requirements, and expectations.

Activity 3: HRSA/BPHC staff also participated on a site visit to a tribal group in Wyoming to discuss the requirements for the Health Center Program.

Expected Outcomes:
Level of funding and access to primary care for AI/AN will be increased and potential applications for community health center funding, planning and development of primary medical care practices will continue to expand. Improved communication between HRSA/BPHC and AI/NA that allows for identification of AI/NA health care needs for the improvement of health services to the AI/NA communities

Divisions and Other Groups Involved in Addressing Priority: Primary Care Associations, Primary Care Organizations, CMS, IHS

Substance Abuse and Mental Health Services Administration (SAMHSA)

PRIORITY: Increased Access to HHS grants; Health Promotion and Disease Prevention

Objective: To ensure that Tribes and Tribal organizations receive technical assistance (TA) in relation both to SAMHSA's grant opportunities and infrastructure development; that the Agency focuses efforts on increasing the number of grants received by Tribal entities; and that substantial activities of the Agency are devoted to helping Tribal entities in the area of health promotion and disease prevention, with a special emphasis on suicide prevention and methamphetamine abuse.

Background: Beginning in FY 2005 the SAMHSA Administrator expanded the grants eligibility policy to enable Tribal entities to be eligible for all grants for which States are eligible unless there is a compelling reason to the contrary (such as legislative requirements pertaining to block grants). Any reason for excluding Tribal entities from grant eligibility needs to be justified and approved by the Administrator. In furtherance of this policy change, in FY 2006, SAMHSA initiated several proactive efforts to facilitate the grant application process for Tribes and tribal organizations, which should result in more competitive grant applications from and an increased number of grant awards to Tribes and tribal organizations in FY 2007 and beyond.

The narrative for this Tribal priority segment combines increased grant access with health promotion and disease prevention. It covers TA made available to Tribal entities in FY 2006, and also significant grant awards made to them during the year. SAMHSA's grants variously cover mental and substance abuse disorders, including co-occurring disorders, and their prevention as well as treatment. This segment of Section 1 also implicitly includes the Tribal priority of funding issues, since a major point of emphasis by Tribes – at the regional consultations and the national budget consultation -- is to increase their amounts of funding from HHS Divisions by way of grants and other mechanisms.

Activities:

Activity 1: Increased Access/Technical Assistance to Tribes

Increased Access to Grants

In conjunction with DHHS's Barrier's Access Study report, in June 2006 SAMHSA's Acting Deputy Administrator convened a group of tribal representatives to review agency Requests for Applications (RFAs) from a tribal perspective. This group provided some very insightful comments, and some of their proposed changes have already been incorporated into FY 2007 funding announcements. Other proposed changes may be included in future SAMHSA RFAs.

Technical Assistance to Tribes/Tribal Organizations

SAMHSA's Center for Mental Health Services (CMHS), Division of Prevention, Traumatic Stress and Special Programs (DPTSSP) sponsors three technical assistance projects that serve Tribal grantees and organizations.

The Suicide Prevention Resource Center (SPRC) serves as a national resource for Suicide Prevention, and is developing specific expertise in working with American Indian/Alaska Native populations. The SPRC plays a critical role in advancing a comprehensive, coordinated, and innovative national suicide prevention effort, as outlined in the *National Strategy for Suicide Prevention: Goals and Objectives for Action (NSSP)* and *Achieving the Promise: Transforming Mental Health Care in America*. The SPRC provides technical assistance to tribal grantees and any other Tribes and Tribal organizations that request it. Activities include:

- Development of culturally appropriate public education materials for suicide prevention and promotion of mental health;
- Identification and dissemination of best practices in risk assessment and intervention; and
- Providing ongoing outreach and training to indigenous communities to respond to their technical assistance needs.

The SPRC received $3.5 million in FY 2006 funds.

The National Suicide Prevention Lifeline (NSPL) routes calls from anywhere in the United States to a network of certified crisis centers, and has developed a Native American Community Liaison Initiative to strengthen communication and collaboration between crisis centers that are part of

NSPL's network and the communities they serve where there are populations of indigenous people. The technical assistance activities include:

- Promoting a dialogue among interested stakeholders on effective crisis line support services that results in goals, action steps, and follow up to success in implementation
- Helping to identify partnership opportunities among crisis centers and community caregivers or other community members that help to ensure that cultural competency training and culturally appropriate educational materials are provided to crisis centers, and facilitating the inclusion of local community input into the development of suicide prevention training and materials.
- Collaborating with Social and Health Services, a social marketing agency working with NSPL on behalf of SAMHSA, to identify effective NSPL educational materials and distribution channels for Native American communities.

The National Suicide Prevention Lifeline received $2.5 million in FY 2006 funds.

The Native Aspirations Initiative, which was first funded in FY 2005, was continued and an additional $795,000 was awarded in FY 2006 to provide proactive mental health assistance to children, youth, and their families living on Indian reservations and in Alaska Native villages to decrease the risk factors that contribute to school violence and suicide, and to increase the protective factors that are linked to the healthy and safe development of children and their families. Specific technical assistance activities provided to 15 sites include:

- facilitation of community planning and selection of culturally appropriate evidence based interventions;
- training of community members in the selected evidence-based interventions;
- ongoing consultation during the implementation of the evidence-based interventions; and
- technical assistance to establish sustainability of the interventions within the community.

Through this effort, the Government seeks to reduce risk behaviors – such as acts of violence and suicidal gestures – by tribal youth and increase pro-social and help seeking behaviors.

SAMHSA's Center for Mental Health Services (CMHS), Child Adolescent and Family Branch (CAFB) participates in two Interagency Agreements (IAG) that fund tribal-specific technical assistance centers for tribal child and adolescent mental health.

- An IAG with the Indian Health Service, which contracts with the National Indian Child Welfare Association (NICWA) for $800,000 to provide community-based, program development technical assistance for the seven Tribes and tribal organizations that receive Child Mental Health Initiative cooperative agreements and the seven Tribes and tribal organizations that receive Circles of Care discretionary grants.

- The second IAG goes to the National Institute of Health, National Center on Minority Health and Health Disparities who contracts with the University of Colorado's National Center for American Indian/Alaska Native Mental Health Research for $400,000 to provide evaluation technical assistance to the seven Tribes and Tribal organizations that receive Circles of Care (discretionary) grants.

CMHS' Child Adolescent and Family Branch (CAFB) has a $100,000 contract with the Georgetown University Child Guidance Center to develop a tribal specific policy academy that will focus on Wellness and Suicide Prevention. The contractors have worked closely with Indian

organizations such as the National Indian Health Board, National Congress of American Indians and the National Indian Child Welfare Association to form an advisory board that will guide the development of the policy academy, which is tentatively scheduled to be held in late 2007.

SAMHSA's Center for Mental Health Services (CMHS) also funds *The National Center for Mental Health Promotion and Youth Violence Prevention* (the TA Center) that supports Safe Schools/Healthy Students (SS/HS) grantees. The TA Center helps grantees to plan, implement, evaluate, and sustain activities that foster resilience, promote mental health, and prevent youth violence and mental and behavioral disorders. Grantees' work focuses on carrying out evidence-based interventions to foster well-being and resilience at the individual, family, and community levels. The TA Center received $5.3 million in FY 2006 funds.

SAMHSA's Center for Substance Abuse Treatment (CSAT) conducted an American Indian/Alaska Native Grant Writing Workshop on August 8-10, 2006 in Santa Fe, New Mexico. The 3-day workshop consisted of interactive discussions on preplanning and organizing grant applications, linking to funding opportunities, skill building exercises, understanding funding announcements and the grant review process. The final day of the workshop was held at the Institute of American Indian Arts computer lab to afford the participants hands-on training. Approximately 25 people participated in the training from various tribes and tribal organizations.

CSAT also hosted a Best Practices in Substance Abuse Treatment for American Indians and Alaska Natives Pre-Conference Forum in conjunction with the IHS/SAMHSA National Behavioral Health Conference on June 5, 2006 in San Diego, California. Several 90-minute technical assistance sessions were held at the forum, including

A *Sustainability Planning Guide* session that covered a wide range of topics related to project sustainability, including: mission, vision and strategy; governance and leadership; resource development; program delivery and impact; strategic relationships; and internal operations and management.

A *Methamphetamine Treatment Centers of Excellence – Program Manual* session that provided information on Arizona's Methamphetamine Treatment Centers for Excellence Initiative, one of which is on the Gila River Indian Reservation and is providing a focused approach for implementing evidence-based practices in the treatment of clients with methamphetamine use disorders. This initiative is jointly sponsored by SAMHSA/CSAT Pacific Southwest Addiction Technology Transfer Center and the Arizona Department of Health Services.

A *Declaring Healing on Methamphetamine in Indian Country* session that focused on Wellbriety strategies—sober lifestyles, wellness-balance (mental, physical, spiritual and emotional); connected to principles, values, and natural laws; Walking the Red Road—to address methamphetamine use in Indian Country.

A *Matrix Model: An American Indian and Alaska Native Perspective* session that introduced the Matrix Model Outpatient Treatment Client Manual Culturally-Adapted for American Indians/Alaska Natives for use with the Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders. The adaptation stemmed from a technical assistance request from a SAMHSA/CSAT Native American grantee, the Friendship House, for culturally appropriate treatment model for clients who suffer from stimulant use disorders.

SAMHSA's Center for Substance Abuse Prevention (CSAP) conducted special outreach efforts to tribal organizations, to assist them in applying for a Strategic Prevention Framework State Incentive Grant. As a result of this effort, 16 tribal entities' applied and 5 were funded for a total of $5,520,755. In order to help ensure grantee success in meeting the objectives of the Strategic Prevention Framework State Incentive Grant (SPF-SIG), CSAP has established a monthly call to the five tribes funded under the Strategic Prevention Framework State Incentive Grant (SPF SIG) Program. The Division Director, the SPF SIG Coordinator, and the five project officers for the grantees participate in the call. The purpose of the initial call was to introduce the federal staff who have responsibility for the grants, gather information about the grantees, discuss respective roles and responsibilities, begin to establish a Native American Grantee Learning Community, and respond to grantee questions.

Technical assistance to the SPFSIG Tribal Grantees as well as Programs of Regional and National Significance (PRNS) for Tribal Grantees will be conducted by the CSAP Centers for the Application of Prevention Technology (CAPTS). Technical assistance will be provided to the tribal organizations in the same manner as a funded PRNS grantee (i.e. Meth or HIV) or States due to their status as sovereign nations. The SPFSIG States also will be able to receive technical assistance on the first step of the SPF-Assessment with respect to the design and implementation of epidemiological a workgroups.

Activity 2: Assistance to Tribal Entities Following Tribal Visits and Meetings

Based in part on meetings with tribal leaders at the Crow Nation and the Northern Arapaho Tribe, SAMHSA joined forces with the HHS Office of Minority Health and the National Institutes of Health on an HHS Tribal Methamphetamine Initiative in 2006. Through this federal collaboration, nearly $1.2 million was awarded to the American Association of Indian Physicians (AAIP) and its partners to address the outreach and education needs of Native American communities on methamphetamine (meth) abuse.

The partners will develop a national information and outreach campaign and a culturally-specific methamphetamine abuse education kit, document and evaluate promising practices in education on meth use, and create meth awareness multi-disciplinary education teams. This project brings federal, tribal, state, and local resources together to reach urban and rural Native American communities and families.

The AAIP, of Oklahoma City, OK, will partner with: the Oregon Health and Science University-One Sky Center, Portland, OR to serve as the principal expert for behavioral health, mental health and substance abuse regarding methamphetamine abuse; the National Congress of American Indians, Washington, DC, to provide technical assistance on a national scale in Indian country; the United South and Eastern Tribes, Nashville, TN and the Northwest Portland Area Indian Health Board, Portland, OR to contribute regional expertise and track data and trends within their respective regions.

The five tribal sites include: the Winnebago Tribe**,** which has been funded as a prevention site; the Navajo Nation and the Northern Arapaho Tribe, which are intervention and treatment sites; and the Crow Tribe and Choctaw Nation, which are treatment and recovery sites.

As a result of the HHS Region V Tribal Consultation in April 2006, former SAMHSA Administrator Charles Curie directed staff from the Office of the Administrator and Center for Mental Health Services to provide technical assistance to the Red Lake Band of Chippewa Indians on children's mental health issues in the ongoing aftermath of the tragic shootings in March 2005. SAMHSA staff held a series of conference calls with key service providers from the Tribe and the local IHS Hospital around issues of behavioral health service coordination for children of elementary and middle school age. SAMHSA also supported the travel of a three person team to attend the Children's Systems of Care Training Institute in Florida. In

addition, SAMHSA staff provided written materials on children's mental health, service integration and early intervention to the Tribe and assisted in planning a children's services conference in Bemidji, Minnesota that was focused on Red Lake and the other two reservations in northern Minnesota.

Expected Outcomes: The primary expected outcome is an increase in the numbers of Tribes and Tribal organizations applying for and receiving SAMHSA grants and services. GPRA data are collected on SAMHSA discretionary grants that will demonstrate to what degree there are significant returns on funds invested. In addition, SAMHSA's National Outcome Measures (NOMs), consisting of 10 measurable domains, will measure the outcome of programs and services provided. Full reporting on the measures – which will include information on American Indians and Alaska Natives – is expected by the end of 2007. In developing the measures, SAMHSA has identified meaningful, real life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities.

Through SAMHSA grant funds and SAMHSA's participation in the HHS Tribal Methamphetamine Initiative it is expected that Tribes will continue to develop and implement culturally-relevant suicide prevention and substance abuse strategies that have replication potential so that they may be shared with or adapted to other tribal communities. Furthermore, by traveling to Indian County and meeting directly with tribal leaders of the HHS Tribal Methamphetamine Initiative sites selected for prevention intervention, treatment and recovery efforts, SAMSHA and HHS Leadership have garnered critical buy-in from tribal leadership that should lead to the successful implementation of this initiative at these five tribal sites.

FY 2006 SAMHSA Grant Awards to Tribes

In FY 2006, SAMHSA awarded $43,727,000 in targeted and discretionary funding to Tribes and tribal organizations for prevention, treatment and recovery support services. The funds will support culturally relevant programs to promote mental health and prevent suicide, mental illness and substance abuse--especially methamphetamine use. Discretionary grant awards included:

Recovery Community Services Program

Tohono O'odham Nation, Sells -- $350,000 for the first year to implement a comprehensive peer-to-peer system to support individuals in recovery with a full range of recovery support services provided locally in the 11 districts that make up the federally recognized tribe, which has one of the highest rates of substance abuse among all populations in the United States.

State-Sponsored Youth Suicide Prevention and Early Intervention Program are:

Maniilaq Association - - $400,000 in the first year and similar amounts in subsequent years to provide a variety of prevention approaches to a region that has one of highest youth suicide rates in the world. The project will include both a cultural and educational component. A media campaign will help to underscore the fact that suicide is preventable and unacceptable within an Inupiat (an Alaska Native culture) context. A cultural renewal film project will enhance cultural continuity and increase youth resilience-- two factors linked to lower suicide rates. The educational component will focus on school and community prevention training and will increase community level protective factors and decrease risk factor.

Tohono O'odham Nation, Sells, Arizona - - $400,000 in first-year funding to implement a public private partnership-built program to address the risk factors leading to youth suicide, including substance abuse, using evidence-based practices appropriate to the Tohono O'odham Nation.

White Mountain Apache Tribe, in Collaboration with Johns Hopkins University, White River -- $400,000 in the first year to collaborate to expand its suicide

prevention initiative by implementing an integrated three-tier suicide prevention approach using culturally adapted, piloted and evaluated evidence-based interventions that address youth suicide risk and protective factors on the individual, family and community levels. Tier one focuses on community education about suicide risk factors and prevention. Tier two addresses the needs of youth with suicide risk factors. Tier three serves youth who have attempted suicide.

United American Indian Involvement, Inc., - - $400,000 in the first year and similar amounts in subsequent years to implement a Youth Suicide Prevention and Early Intervention Project targeting American Indian and Alaska Native children and youth ages 10-24 in Los Angeles County. The program will collaborate with other agencies, providers and organization to share information and resources by promoting awareness that suicide is preventable. The program will develop a culturally appropriate youth suicide prevention and intervention effort to include screening, gatekeeper training, and enhanced, and accessible crisis services and referrals sources.

Standing Rock Sioux Tribe, Fort Yates, North Dakota - -$400,000 in the first year to implement Okolakiciye Unyukinipi ("Revitalizing our Societies") that will bring together tribal leaders, service providers, youth and faith community leaders to implement a comprehensive tribal youth suicide prevention and early intervention plan that will identify and increase youth referral to mental health services and programs, increase protective factors and reduce risk factors for youth suicide, and improve access to prevention and early intervention programs.

State of South Dakota, Pierre, South Dakota - - $400,000 in the first year to implement suicide prevention and early intervention programs in high schools and universities targeting youth ages 14-24, parents, staff and community "gatekeepers," providing awareness, training and education and establishing linkages among schools, mental health centers and substance abuse treatment providers through referral and post-intervention protocols. Among the partners are Sinte Geleska University on the Rosebud Indian Reservation and Wakanyeja Pawicayapi on the Pine Ridge Indian Reservation.

Montana Wyoming Tribal Leaders Council - - $390,751 in the first year and similar amounts in subsequent years to increase tribal awareness of suicide-related issues, reduce suicidal behavior among tribal youth, and improve access to suicide prevention services for American Indian people. This project will bring prevention efforts to six Montana and Wyoming American Indian Reservations, serving the Blackfeet, Crow, Northern Cheyenne, Fort Peck, Fort Belknap and Wind River populations.

State of Wyoming, Cheyenne, Wyoming - - $400,000 in the first year to reduce the rate of suicide among state youth, ages 10-24, with a special emphasis on Native American youth and college students, through better statewide coordination (including the establishment of a statewide youth suicide prevention advisory council), school-based programming, community-based prevention programming, a pilot program for high-risk youth and anti-stigma/public awareness.

Child Mental Health Services Grants

Pascua Yaqui Tribe, Tucson, Arizona - - $1,000,000 for the first year to develop the Sewa Uusim program, a sustainable tribal system of care for children with severe emotional disturbance (SED) and their families that is culturally-based and consistent with evidence-based practices, utilizing a wraparound service methodology that incorporates community members as caregivers and family members as advisors.

Strategic Prevention Framework Incentive Grants

Cook Inlet Tribe Council, Inc., Anchorage, Alaska -- $1,633,546 for the first year will support a tribal infrastructure development project to establish a solid foundation for

delivering and sustaining effective substance abuse prevention services for the Anchorage tribal community.

Native American Health Center, Inc., Oakland, California - - $1,455,143 for the first year to support the One with All program to expand the capacity of Northern California tribal organizations to provide culturally appropriate, evidence-based substance abuse prevention services for American Indians and Alaska Natives in the region. Built on the principles of the strategic prevention framework, it will include not only a needs assessment and development of a comprehensive strategic plan, but also an in-depth evaluation of the approaches utilized and their impact on the growing community.

Grand Traverse Band of Ottawa and Chippewa, Peshawbestown, Michigan - - $513,831 for the first year to work in partnership with the Michigan Public Health Institute's Center for the Collaborative Research in Health Outcomes and Policy to implement, evaluate, and sustain a strategic prevention framework-focused substance abuse prevention effort among the population of the Grand Traverse Band. The program is designed to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking.

The Cherokee Nation, Tahlequah, Oklahoma - - $2,093,000 in the first year to forge a comprehensive, data-driven, community-based integrated system of prevention across the nation. This substance abuse prevention system will provide the infrastructure for delivering and sustaining effective, efficient, and culturally appropriate substance abuse prevention services to American Indian citizens who live in the area served by the tribe.

Great Lakes Intertribal Council, Inc., Lac du Flambeau, Wisconsin - - $1,104,835 for the first year to develop and implement the Great Lakes Intertribal Council Strategic Prevention Framework State Incentive Project to help the 11 tribes of Wisconsin build the infrastructure and capacity needed to better prevent substance abuse in their communities, with an emphasis on underage drinking.

Grants to Prevent Methamphetamine Abuse

Cherokee Nation, Tahlequah, Oklahoma - - $350,000 in first-year funding to forge a comprehensive, community-base, integrated system to prevent methamphetamine abuse for American Indian children and adolescents. The preventive intervention will be culturally appropriate, use known-effective program elements, and engage the active participation of community members in development and implementation.

Native American Rehabilitation Association of NW, Inc., Portland., Oregon - - $350,000 in the first year to implement Raising Our Seventh Generation, a pilot program to identify innovative methodologies to prevent, reduce or delay methamphetamine abuse among young Native American children whose parents are in treatment for methamphetamine abuse, including culturally relevant program components to develop or strengthen known protective factors for young children at risk of drug use.

Treatment for Homeless Program (Supplement)

Cook Inlet Tribal Council, Inc. Anchorage, Alaska - - $199,808 for one year to add five residential treatment beds for homeless chronic inebriates who are Alaskan Natives or American Indians. This program will provide comprehensive, coordinated case management services.

PRIORITY: **Recruitment and Retention of Care Providers**

Objective: To support programs and educational efforts that encourage the development of a cadre of professional racial/ethnic minority service providers who understand and competently address the needs of American Indians and Alaska Natives in the

fields of substance abuse and mental health services.

Background: One of SAMHSA's cross-cutting principles for managing programs and initiatives is a focus on cultural competency and elimination of disparities in the incidence of mental illness and substance abuse. The Agency's Minority Fellowship Program is an ongoing and long-term effort to recruit appropriate care providers for American Indians and Alaska Natives and other racial/ethnic minorities. In addition, SAMHSA's Addiction Technology Transfer Centers were designed to facilitate workforce development, which also addresses the recruitment of care providers.

Activities:

External

The SAMHSA Minority Fellowship Program (MFP) is a key activity in relation to recruiting and retaining care providers. The purpose of the MFP is to facilitate the entry of racial/ethnic minority students, including American Indians and Alaska Natives, into mental health and substance abuse related careers. Since the program began, more than thirty years ago at the National Institute of Mental Health, the MFP has helped to support doctoral-level training of almost 1,000 racial/ethnic minority psychiatrists, psychologists, psychiatric nurses, and social workers. These individuals often serve in key leadership positions in mental health and substance abuse direct services, services supervision, services research, training, and administration. In FY 2005, two-year MFP grants were awarded to the American Psychiatric Association, American Psychological Association, American Nurses Association and Council on Social Work Education.

For the first time in FY 2005, the CMHS Tribal-specific Circles of Care grant program included tribal colleges and universities as eligible entities. In a related vein, CMHS continues to facilitate the incorporation of traditional healers in Circles of Care projects, as well as the Child Mental Health Initiative. In addition, CSAT, with its Targeted Capacity Expansion grants, continues to support traditional Native healing practices when applicant Tribes and entities propose to use such models among Indian populations.

SAMHSA's Prevention Pathways web site (http://preventionpathways.samhsa.gov) offers professionals access to training courses and continuing education units. SAMHSA's Addiction Technology Transfer Centers Network has 14 regional centers and a national office. Established in 1993, the ATTC network is dedicated to conveying the latest scientific knowledge to the field to improve the work of addiction treatment practitioners. The ATTCs' primary purpose is to increase clinical practice knowledge and skills of addiction treatment practitioners by facilitating access to state-of-the-art research and education. Serving as resource centers, the network creates initiatives, services, and products as specific local or national needs emerge.

Internal

In May 2006 the SAMHSA Matrix of Program Priorities was expanded to include workforce development and suicide prevention. The priorities identified in the Matrix are the result of discussions with SAMHSA advisory councils, members of congress, people working in the field, researchers, advocacy and constituency groups, family members, and people working to obtain and sustain recovery.

In conjunction with this announcement, SAMHSA established the Cultural Competence and Eliminating Disparities (CCED) Workgroup as a way of addressing behavioral health disparities and ensuring that cultural competence becomes an integral part in every policy, grant, and program supported by SAMHSA. In addition to infusing cultural competence into the external workforce, this Workgroup is examining ways to infuse cultural competence into the federal workforce at SAMSHA.

In September 2006 SAMHSA established a Senior Advisor for Tribal Affairs position in the

Office of Policy, Planning and Budget (OPPB) in order to improve overall coordination of SAMHSA tribal activities within the agency and provide increased outreach to tribal communities.

SAMHSA continues to participate in the American University program, Washington Internships for Native Students (WINS), which provides work experiences for American Indian/Alaska Native students in a variety of fields, including mental health and substance abuse. This has provided richly rewarding experiences for both the students and the SAMHSA workforce.

Expected Outcomes:

These activities are expected to contribute to increasing the pool of culturally competent care providers in the fields of mental health and substance abuse in the field and internally within the federal workforce at SAMHSA.

REGIONAL TRIBAL PRIORITIES

Region II

PRIORITY 1: **To improve the relationship between HHS and the Tribes.**

Objectives: a) Foster an open, two-way communication with the Tribes; b) Offer the Tribes ongoing support, guidance and participate in tribal events and activities throughout the year.

Background:
Native American tribes feel strongly that the relationship between the Federal government and the Tribes should be one of respect, understanding and equality. The relationship should be considered as a nation to nation relationship.

Activities:

Activity 1: The Region II Administration on Aging (AOA) held three listening sessions this year. Among the items discussed were Title 6 program reports, preventative health, Medicare & other issues of mutual concern and interest.

Activity 2: The Region II Administration for Children and Families (ACF) facilitated, together with National Child Care Information Center (NCCIC), a collaboration meeting at the 2006 State Administrators Meeting (SAM). St. Regis Mohawk Tribal Government Child Care Administrators met with the New York State Child Care Administrator and agreed to work more closely to ensure effective child care services to families who live and work in their communities.

Activity 3: The Region II Centers for Medicare and Medicaid Services (CMS), in conjunction with the Office of the Regional Director (ORD), held quarterly conference calls with tribal leaders from the region.

Activity 4: Region II ORD and Office of Public Health and Science (OPHS) conducted on-site visits to the Tribes.

Expected Outcomes: a) Establish and promote a strong working relationship with the Tribes on a government-to-government basis. b) Establish a strong relationship with the Tribes based on trust by offering valuable advice and assistance.

Divisions and Other Groups Involved in Addressing Priority:
U.S. Department of Health and Human Services

- Office of Regional Director
- Office of Intergovernmental Affairs
- Office of Public Health and Science
- Centers for Medicare & Medicaid
- Administration for Children and Families
- Administration on Aging

PRIORITY 2: **Pandemic Flu Tribal Community Planning.**

Objective: To provide substantial guidance and technical assistance to Tribes as they prepare to respond to a possible influenza pandemic. Among other things, HHS and its operating divisions will coordinate pandemic response

activities with state, local and tribal public health and health care agencies; support state pandemic planning efforts; communicate and disseminate timely influenza pandemic information and provide technical guidance to local public health departments and health care agencies with a particular focus on the Tribes.

Background: A pandemic influenza is the global spread of an influenza virus where there is limited human immunity. A pandemic influenza is distinct from the familiar seasonal "flu" viruses. While most humans have some degree of immunity to flu viruses, we would have limited internal immunity to pandemic influenza viruses; therefore, the severity of illness would be greater. The avian influenza virus strain known as H5N1that is currently circulating in Asia is considered to be a possible pandemic candidate. To date, the majority of human cases of avian influenza have been among individuals living in close contact with birds (e.g., poultry farmers), and the transmission pattern has only been from bird to human. There have been a few instances of possible human to human transmission, but so far, sustained human to human transmission has not been seen. If the virus evolves to allow more efficient human to human transmission, then a pandemic becomes more likely.

Activities:

Activity 1: At the New York State Pandemic Flu Summit held in July, 2006, the Regional Emergency Coordinator met with the St. Regis Mohawk Tribe to discuss initiatives in planning for pandemic influenza. OPHEP and OPHS will continue to work with the Tribes to develop their Emergency Preparedness Community Plan.

Activity 2: Tuscarora Environment Program and Emergency Management representatives participated in a two day Crisis Emergency Risk Communication (CERC) training hosted by the ORD and CDC.

Activity 3: The ORD has worked with New York State to ensure that the State's Operational Plan for Pandemic Influenza Response include the Tribes as an integral element of the local emergency response plan.

Expected Outcomes: The ORD, in addition to the REC, will ensure Tribal collaboration in all pandemic flu planning.

Divisions and Other Groups Involved in Addressing Priority:
U.S. Department of Health and Human Services

- Office of Regional Director
- Office of Intergovernmental Affairs
- Office of Public Health and Science
- Office of Public Health Emergency Preparedness (OPHEP)
- Centers for Disease Control and Prevention
- New York State
- Office of the Governor

PRIORITY 3: **a) To establish a close working relationship between HHS and the Tribes to develop tools for measuring and collecting data pertinent to tribal community needs. b) To promote culture, in additional to other factors, in obtaining new and additional funding.**

Objectives: a) To utilize incoming funds from HHS to enhance collaboration among programs that share common caseloads. b) To establish common goals and potential earmarks related to grant funding and expenditures.

Background: HHS funding is not increasing at the same rate as the increased needs for services. Demand for services is rising astronomically and the Tribes are having budget issues and problems maintaining and recruiting staff due to low competitive wages. Tribal communities and organizations are going through rapid inflationary growth and yet they operate with the same general funding.

Activities:

Activity 1: The Office of Minority Health (OMH), in collaboration with the ORD, coordinated tribal visits to the Seneca Tribe in June and the St. Regis Mohawk Tribe in August.

The visit to the Oneida Nation was postponed twice and has been rescheduled for the spring of 2007. Agencies invited to attend the visits included ACF, OPHEP and OPHS. The primary purpose of these visits was to have a dialogue with Tribal leaders regarding their funding needs and HHS funds that might be available.

Activity 2: OMH provided funds for the Seneca nation to attend and participate in a Health Prevention Summit on October 2006.

Activity 3: OMH and Office of Women's Health (OWH) facilitated the participation of three tribal nations in the planning committee of the Healthy People 2010 Summit. Tribal nations also made presentations at the summit regarding best practices, traditional healing practices and the use of complementary and alternative medicine.

Activity 4: OWH invited the Tribes to participate in the Body Works Obesity Prevention Toolkit Training. The Seneca and St. Regis Mohawk Tribes participated.

Activity 5: The ORD participated in the CMS regional quarterly Tribal conference calls. Tribes were given the opportunity to ask questions and voice their concerns regarding any issue, including Medicare Part D.

Expected Outcomes:

a) Tribes will be consulted on matters that affect their land and well-being.

b) Tribes will be invited to participate as a partner in all HHS regional meetings and efforts.

c) The ORD will assist the Tribes to become familiar with HHS through on-site assistance, technical support and training.

Divisions and Other Groups Involved in Addressing Priority:

U.S. Department of Health and Human Services

- Office of Regional Director
- Office of Intergovernmental Affairs
- Office of Public Health and Science
- Centers for Medicare & Medicaid
- Administration for Children and Families
- Centers for Disease Control and Prevention
- Substance Abuse & Mental Health Services Administration

PRIORITY 4: **Improve interstate agreements between NY State Tribes and out of state facilities.**

Objective: To improve the communication between the Tribes and the State of New York in order to facilitate the billing and reimbursement of services offered in out of state facilities.

Background:

Interstate agreements do not specifically address the ability of Tribes to bill and be reimbursed for out of state services. A tribe can only bill for out of state services if providers are enrolled as a New York State providers.

Activities:

Activity 1: Have NYS representatives participate in the consultation sessions every time there is a Region II meeting.

Activity 2: The ORD will continue to serve as a liaison whenever necessary between the Tribes and NYS Medicaid.

Expected Outcomes: The ORD will continue to provide assistance on this issue and link the tribes to the appropriate State agencies and officials.

Divisions and Other Groups Involved in Addressing Priority:

U.S. Department of Health and Human Services

- Office of Regional Director
- Office of Intergovernmental Affairs
- Office of Public Health and Science
- Centers for Medicare & Medicaid
- Administration for Children and Families
- Substance Abuse & Mental Health Services Administration
- New York State
    - DOH Medicaid

    - DOH American Indian Health Program
- Office of Children and Family Services

Section 2
Overview of Consultation Activities

SECTION 2: OVERVIEW OF CONSULTATION ACTIVITIES

HHS ANNUAL TRIBAL BUDGET CONSULTATION SESSION

The Office of Intergovernmental Affairs (IGA) is responsible for facilitating the Annual Tribal Budget Consultation Session and the Divisional Budget Consultation Session. IGA worked closely with the Office of the Assistant Secretary for Resources and Technology, (ASRT), Administration for Native Americans (ANA), Indian Health Service (IHS) and Office of Minority Health (OMH). HHS hosted the 1st Annual National Divisional Tribal Budget Formulation and Consultation Session on March 11, 2006 and the 8th Annual National Tribal Budget Consultation Session on May 16-17, 2006. Alex Azar, Deputy Secretary, and Kerry Weems, Deputy Chief of Staff, provided opening remarks. Moderators of the formal consultation session included Regina Schofield, former Director, Office of Intergovernmental Affairs, Charles Johnson, Assistant Secretary for Resource and Technology, Jefferson Keel, 1st Vice President National Congress of American Indians and H. Sally Smith, Chairman, National Indian Health Board. Also leading the HHS discussion was the Intradepartmental Council on Native American Affairs (ICNAA) Vice-Chair, Dr. Charles W. Grim, Director, Indian Health Service. Senior staff attended the session throughout the day and a half session.

Tribal representation included National Congress of American Indians, National Indian Council on Aging, National Indian Health Board, United South and Eastern Tribes, Northwest Portland Area Indian Health Board, California Rural Indian Health Board, National Indian Headstart Association and 30 individual Tribal Leaders/Representatives. Tribal leaders presented formal testimony and attended sessions with HHS divisions to discuss policy and budget matters impacting their local communities. Tribes raised and proposed strategies to resolve issues within the broader categories of budget, consultation, legislation, regulation, research, and HHS programs and policy. More specifically, concerns were mentioned regarding small budget increase in comparison to CMS and inflation; key pieces of legislation; developing a research agenda for Indian Country that is inclusive of Indian researchers and implemented in the communities; relationships between states and Tribes; technical assistance to Tribes; and HHS grant policies and mechanisms, i.e. direct funding to Tribes instead of states and longer grant terms to reflect long-term strategies.

One key area of interest throughout the consultation was suicide and methamphetamine abuse across Indian Country. Topics of discussion included chronic disease prevention and management; health promotion; addressing diseases and health issues, such as hepatitis C, alcoholic liver disease, diabetes, hypertension, stroke, HIV/AIDS, STDs, tuberculosis; injury prevention and control, substance and tobacco abuse, nutrition, physical activity, obesity, high suicide rate, cardiovascular disease, and oral health care; health disparities; under-enrollment of Native Americans in Medicare and Medicaid. Other topics of focus included TANF; Head Start; child care; child welfare and protective services; children's mental health and suicide; elder social services; environmental issues; and emergency preparedness.

Responses to Tribal perspectives were made by HHS senior staff, including Charles Johnson, Assistant Secretary for Resources and Technology; Frank Burns, Deputy Assistant Secretary, Center for Wellness and Community Based Services; Yvonne Jackson, Director, Office for American Indian, Alaskan Native and Native Hawaiian Programs; Stephen Wade, Director of Budget Office; Dr. Eric Broderick, Acting Deputy Administrator; Clifton Poodry, Director Division of Minority Opportunities and Research, National Institute General Medical Science; Kathie Kendrick, Deputy Director, AHRQ; Walter Williams, Director, Office of Minority Health, Centers for Disease Control; Dr. Charles W. Grim, Director, Indian Health Service, Dr. Craig Vanderwagen, Chief Medical Officer, ADM Gary Hartz, Director, Office of

Environmental Health and Engineering ,Ms. Elizabeth Fowler, Director, Division of Budget Formulation; Dennis Williams, Deputy Administrator, Heath Resource Service Administration; Dr. Mark McClellan, Administrator, Centers for Medicaid & Medicare Services, Wes Perich, Director, Budget and Analysis Group; Garth Graham, Deputy Assistant Secretary for Minority Health, Director Office of Minority Health

HHS LEADERSHIP VISITS TO INDIAN COUNTRY

HHS senior staff has been visiting Indian Country regularly for more than five years. In 2006, HHS senior staff continued this tradition. This travel has been at the invitation of Tribal leaders who have repeatedly stated that there is no substitute for seeing health and human service conditions first hand in Indian communities.

Director of Minority Health Phoenix Trip
On May 2, 2006 Dr. Garth Graham visited the Phoenix Area where he led a discussion at the Region 9 Tribal Consultation Session on methamphetamine abuse in Indian Country with Tribal leaders. He then toured the Phoenix Indian Medical Center, and tour of the Gila River Community. He was accompanied by Westley Clark, Substance Abuse Mental Health Service Administration, Love Foster-Horton, Substance Abuse Mental Health Service Administration, John Perez, Indian Health Service and Stacey Ecoffey Office of Intergovernmental Affairs.

Assistant Secretary for Health Montana Trip
Assistant Secretary for Health Dr. John Agwunobi visited the State of Montana June 25-27, 2006. He was accompanied by Dr. Eric Broderick, Acting Deputy Administrator, Substance Abuse Mental Health Service Administration, Laura Caliguiri, Deputy Director Office of Intergovernmental Affairs, Mirtha Beadle, Deputy Director Office of Minority Health, James Stone, Acting Director of Behavioral Health, Indian Health Service, Joe Nunez, Region 8 Director Office of Intergovernmental Affairs, Pete Conway, Billings Area Director Indian Health Service; and IGA Tribal Affairs staff Stacey Ecoffey and Harold Brien. The Assistant Secretary for Health hosted a Tribal Leaders Roundtable with the Billings and Aberdeen Areas on methamphetamine abuse in Indian Country. He then visited the Crow Nation of Montana.

Deputy Secretary Alaska Area Visit
Deputy Secretary Azar visited the State of Alaska. He was accompanied by Jim O'Neill, Deputy Secretary's Office, Charles Grim, Director Indian Health Service, Laura Caliguiri, Deputy Director, Office of Intergovernmental Affairs, Vince Ventimiglia, Assistant Secretary for Legislation, Leslie Norwalk, Deputy Administrator Centers for Medicaid & Medicare Services, Quanah Crosland-Stamps, Commissioner Administration for Native Americans Arne Owens, Substance Abuse Mental Health Service Administration; James Whitfield, Regional Director, Region X; Chris Mandregan, Alaska Area Director, IHS; and IGA Tribal Affairs staff Stacey Ecoffey and Kim Romine. He was also accompanied during a portion of the trip by policy staff for Senator Murkowski, Senator Stevens, Congressman Young, and Governor Murkowski. The Deputy Secretary visited Anchorage, Saint Paul, Bethel, Sitka, Ketchikan and Metlakatla, touring HHS programs and services, and meeting with state officials and local community members throughout the week. In addition, he held a press conference in Sitka, Alaska.

INTRADEPARTMENTAL COUNCIL ON NATIVE AMERICAN AFFAIRS (ICNAA)

Intradepartmental Council for Native American Affairs: The Intradepartmental Council for Native American Affairs met twice in 2006. The Council membership includes the heads of each HHS Division and serves as the Secretary's principal advisory body on Tribal policy matters. Six ICNAA Priorities for FY06 include: Health Promotion and Disease Prevention; Health Professions Recruitment; Tribal Consultation; Emergency Preparedness; Increase Awareness and Effectiveness of Human Services with Native Populations; and Increase Access to HHS Programs and Grants - Improve technical assistance for all AI/AN/NAs

IGA provides ongoing executive direction for the ICNAA. This is coupled with IGA's consultation responsibilities to receive the views of Indian Tribes and to ensure their inclusion in the policy development guided by ICNAA.

DIVISION- AND REGION-SPECIFIC TRIBAL CONSULTATION

Periodically, even though Divisions and Regions participate in National and Regional-Level Tribal Consultation, they may conduct independent sessions at which Tribal consultation occurs. Additionally, ongoing consultation efforts through written communication and other means occur throughout the year.

DIVISION-SPECIFIC TRIBAL CONSULTATION

Date	Event	In Attendance	Summary
Administration for Children and Families (ACF)			
12/6-9/2005	ACF National Native American Conference and Tribal Consultation Palm Springs, CA	ACF Assistant Secretary Horn; Indian Health Service (IHS) Director Grim; ANA Commissioner Stamps; ANA Deputy Commissioner Romine; ANA Director of Program Operations Cooper; ACF Tribal Agency staff; Tribal leaders and Representatives of Native American organizations.	Met with Tribal Representatives in Consultation on all ACF programs; provided Conference sessions and training on ACF Tribal programs.
ACF/Administration for Native Americans (ANA)			
12/7/2005	National Conference on Service in Indian Country, Reno, NV	ANA Commissioner Stamps; Tribal AmeriCorps youth and Corporation for National and Community Service program directors.	Keynote speech on service in Native communities.
3/8-11/2006	ACF Healthy Marriage Initiative Training and Technical Assistance Conference - Washington, DC	ANA Deputy Commissioner Kimberly Romine; ACF Healthy Marriage Program staff; ACF Healthy Marriage grantees.	Presentation on Native American Healthy Marriage Initiative.
3/14-17/2006	North American Native Wellness Gathering - Reno NV	ANA Commissioner Stamps; Tribal leaders and grantees.	Keynote Speech on community wellness.
4/27/2006	Red Lake Community - Red Lake MN	ANA Commissioner Stamps; Red Lake Tribal Council; Red Lake Community members.	Speech and presentation of gift to acknowledge the recovery process and continued partnership.
8/9/2006	Behavioral Health Roundtable - Anchorage, AK	Deputy Secretary Azar; ANA Commissioner Stamps; Alaska Tribal leaders; Health Directors and State Partners.	Roundtable participant and speaker on ANA Alaska grants and Youth Development.
8/25/2006	ANA Grantees Roundtable - Anchorage, AK	ANA Commissioner Stamps; Current ANA Alaska Grantees.	Announced new 2006 ANA Alaska Grants; discussed impact indicators and received feedback from current grantees on how their projects were progressing.

Date	Event	In Attendance	Summary
9/27/2006	Annual Native Hawaiian Convention	Video presentation by ANA Commissioner Stamps to Hawaiian and Pacific Region community leaders and grantees.	Speech announcing new 2006 ANA grants in the Region and the availability of new Language Guides.
ACF/Children's Bureau (CB)			
6/20-22/2006	State/Tribal Meeting hosted by CB	75 individuals representing Tribes, States, advocacy groups, Resource Centers, Federal Central Office and Regional staff.	Numerous workshops pertaining to Tribal child welfare programs; State/Tribal presentations of state/tribal relationships and collaboration efforts.
ACF/Office of Child Support Enforcement (OCSE)			
Dec., 05; Jan., 06; Jun., 06; Sep., 06	1) Central Council Tlingit and Haida Indian Tribes (CCTHITA), AK; 2) NCSEA Policy Forum, D.C.; 3) National CS Interstate Systems Symposium; 4) OCSE 16th National Training Conference	OCSE, Tribal IV-D Grantee, Potential Tribal IV-D Grantees, States and ACF Regional Staff.	Information relevant to Tribal IV-D Program Operations were presented.
ACF/Office of Community Services (OCS)			
March and May, 06	OCS programs were included in the HHS tribal consultation	HHS and Tribal Governments.	Budget consultation - consult with tribes on HHS budget and funding to the Tribal governments for HHS programs.
Jun., 06	Division of Energy Assistance - National Low-Income Energy Consortium conference in Washington, DC	OCS staff, representatives from more than 40 Tribes, and other home energy and energy assistance providers.	OCS sponsored an interactive tribal workshop on the Low Income Home Energy Assistance Program. OCS staff met with tribal representatives to discuss the Tribes' LIHEAP programs.
ACF/Office of Family Assistance (OFA)			
11/8-9/2005	Training on Financial Management Policies	Federal: OFA - DTTM, ACF Office of Administration (OA) and Office of Family Assistance (OFA) staff. Tribal: Blackfeet, Morongo, Torres Martinez, Washoe, and Mille Lacs Band of Ojibwe program staff, and Tribal representatives.	Provided financial management training to representatives of five Tribal TANF programs. Primary topics included procurement, audits, required management and accounting systems, and a summary of current financial management issues facing a number of our Tribal grantees. During this training, we responded to a myriad of questions and issues raised by the Tribal grantees.

Date	Event	In Attendance	Summary
5/12/2006 -and - 5/19/2006	Two conference calls for Tribes that were considering applying for discretionary grants under OFA's new Tribal TANF - child welfare coordination grants	Federal: OFA staff and staff from ACF Regions V, VI, VII, VIII, IX, and X; Tribal: representatives and staff from 30 Tribal TANF grantees.	Provided information, application instructions and technical assistance on applying for Tribal TANF - Child Welfare Coordination Grants.
7/12-13/2006	Meeting with Regional staff and State and Tribal representatives	Federal: ACF representatives from Regions II, VII, VIII, and X; Tribal: Various Tribal representatives of Tribes, TANF, and NEW programs in the four regions; State: Various representatives from state TANF agencies.	Met and consulted on the TANF provisions contained in the Deficit Reduction Act of 2005 (this consultation was initiated and sponsored by the Governor of Montana and the National Alliance of Tribal TANF).
9/11-12/2006	ACF Region V Tribal TANF Grantees Conference, Chicago, IL	Federal: Ray Apodaca and Gerald Joireman (by phone) - OFA and the Regional Director and staff of Reg. V Tribal Office: 8 TANF grantees plus 3 potential grantee tribes in the region.	Presentations on TANF regulations, reporting, and the Deficit Reduction Act TANF Reauthorization, and provided T/TA in groups and individually as requested.
9/19-21/2006	ACF Regional IX Tribal TANF Grantees Conference, Seattle, WA	Federal: Bob Shelbourne, Ray Apodaca, the Regional Director and staff of Reg. IX, and the Reg. IX Regional Administrator; Tribal: 18 TANF grantees and two potential grantees in the region.	Presentations on TANF regulations, reporting, and the Deficit Reduction Act TANF Reauthorization. Provided T/TA in groups and individually as requested.
10/1/2005 - 9/30/2006	Forty-five conference calls with various tribal officials, Tribal TANF program directors and staff, and other Tribal program staff	Federal: Division of Tribal TANF Management staff; OFA, OA, and Regional Office staff from regions V ,VI ,VII , VIII , IX, and X (as appropriate); Tribal: Tribal Officials, TANF program staff, Tribal administrative staff (e.g. program managers, accounting and financial services, etc.); State: state officials and state TANF program staff (as appropriate).	General and Tribal/program specific issues related to the TANF program such as, plan development, program start-up, administration, audits, management issues, etc.
ACF/Office of Head Start (OHS)			

Date	Event	In Attendance	Summary
12/5-6/2006	ACF Tribal Consultation	Joan Ohl, Frank Fuentes, Ann Linehan, 75 Tribes.	Tribes posed various issues affecting their Head Start Programs. Response, in the form of a letter addressing their concerns, was sent to the Tribes from Frank Fuentes. The main issues dealt with are funding, communication, and monitoring.

Date	Event	In Attendance	Summary
Administration on Aging (AoA)			
Jan. 12, 2006	AoA Tribal Consultation Session, Cabazon, CA	AoA staff and Tribal representatives from the west and southwest	Older Americans Act Reauthorization issues were shared with the tribes. Tribes shared issues they were having concerning an increasing elderly population as well as social service and health issues. Priority issues included: 1) increased funding for Title VI programs; 2) elder abuse issues; and 3) transportation and the high cost of gasoline.
Mar. 23, 2006	AoA Tribal Consultation Session, Nashville, TN	AoA staff and Tribal representatives from the east	Older Americans Act Reauthorization issues were shared with the tribes. Tribes shared issues they were having concerning an increasing elderly population as well as social service and health issues. Priority issues included: 1) reauthorization of the Older Americans Act; 2) increased funding from programs; and 3) additional training opportunities.
Jun. 29, 2006	AoA Tribal Consultation Session, Juneau, AK	AoA staff and Tribal representatives from Alaska and the northwest	Older Americans Act Reauthorization issues were shared with the tribes. Tribes shared issues they were having concerning an increasing elderly population as well as social service and health issues. Of particular concern were the following: 1) funding for programs; 2) transportation; 3) maintaining flexibility in Title VI programs; and 4) implementing the recommendations from the White House Conference on Aging.

Date	Event	In Attendance	Summary
Assistant Secretary for Resources and Technology (ASRT)			

Date	Event	In Attendance	Summary
March 10, 2006	1st Annual National Divisional Budget Formulation and Consultation Session	HHS Assistant Secretary for Resources and Technology, IGA/Tribal Affairs staff, Tribal leaders and representatives, representatives from AOA, SAMHSA, ACF, NIH, AHRQ, CDC/ATSDR, IHS, CMS, OMH, HRSA	Agency representatives and Tribal leaders discussed the cross-cutting issues of pandemic flu, methamphetamine abuse, suicide prevention, and MMA implementation; agencies presented overviews of their budget processes; and Tribal leaders presented their budget priorities
May 16-17, 2006	8th Annual Department Wide Tribal Budget Consultation Session	HHS Assistant Secretary for Resources and Technology, HHS Deputy Secretary, IGA/Tribal Affairs staff, Tribal leaders and representatives, representatives from AOA, SAMHSA, ACF, NIH, AHRQ, CDC/ATSDR, IHS, CMS, OMH, HRSA	Agencies presented overviews of their budget processes and accomplishments; and Tribal leaders presented their budget priorities, including increased funding for child care, child welfare, mental health/behavioral health, MMA implementation, health promotion/disease prevention, research, and chronic diseases.

Date	Event	In Attendance	Summary
Centers for Disease Control and Prevention (CDC)			
October 20, 2005	NIHB's Annual Public Health Day – Division of Reproductive Health (DRH) consultation session relative to the Sudden Unexplained Infant Death Initiative.	DRH staff, NIHB staff and board members, and 95 AI/AN tribal providers and leaders.	DRH in collaboration with partners, launched the Sudden Unexplained Infant Death Initiative (SUIDI) in 2004 to improve and standardize infant death scene investigations and cause-of-death reporting. Its objectives were to revise the SUIDI Reporting Form and to develop a standard training curriculum and materials for those who investigate and determine causes of death. CDC obtained input from attendees as how to proceed with this work in tribal communities and how to engage tribes in developing training materials. Tribal leaders suggested that there be a component relative to the tribes in all regional trainings as well as one training specific to AI/ANs.

Date	Event	In Attendance	Summary
November 15-16, 2005	Division of Diabetes Translation (DDT) consultation session.	DDT and the National Diabetes Wellness Program (NDWP) staff, eight tribal grantees of the Health Promotion and Diabetes Prevention Projects for AI/AN communities: Adaptations of Practical Community Environmental Indicators project.	Grantees and the national Tribal Leaders Diabetes Committee identified a critical need for tribes and tribal organizations to be able to easily obtain technical assistance (TA) from CDC in developing diabetes prevention programs. CDC Wellness Program hired a contractor to provide culturally appropriate TA and utilized this initial meeting to engage funded tribal partners in this activity as well as publicly invite all tribes the opportunity to access this expertise.
2001-2006	CDC National Diabetes Wellness Program (NDWP) seeks ongoing Tribal guidance and formal and informal tribal consultation to guide program efforts and implementation of diabetes work plan.	NDWP staff, the Tribal Leaders Diabetes Committee (TLDC), IHS Division of Diabetes Treatment and Prevention, National Institute of Diabetes, and NIH	TLDC continues to work closely with DDT and NDWP to decrease the diabetes epidemic in tribal nations. The purpose of the Program is to work with tribal nations, tribal organizations, other federal agencies and state governments to eliminate health disparities and increase the quality of life for AI/ANs with or at-risk of developing diabetes.
June 28, August 29 and 30, 2006	Division of Cancer Prevention and Control (DCPC) consulted with all currently funded tribal cancer programs about development of new RFA for 2007. DCPC also did a DTLL inviting all tribal leaders to participate in a series of conference calls hosted by NIHB on August 29 and 30th. NIHB disseminated information through their email alert and Area Health Boards requesting tribal consultation regarding this new program announcement.	13 of the 18 funded tribal programs participated in the initial call. 12 additional tribes/organizations participated on the August calls. Notice of calls and intent was disseminated by NIHB as well as posted on their web page. All interested participants were thanked for their input and told that their input would be considered as DCPC developed the new program announcement scheduled for release early in 2007.	DCPC complied with CDC's Tribal Consultation Policy by consulting with tribes and tribal organizations in the development of a program that has partnered with AI/AN tribes for 12 years. This program has and will continue to impact cancer prevention activities in Indian country and input was greatly desired by DCPC. This process of engaging tribal leaders provided some valuable input into a RFA development. It was felt that this process of engaging tribal leaders can be strengthened and used again as other CDC programs are developing program announcements.

Date	Event	In Attendance	Summary
Oct.13, 2006	CDC AI/AN Public Engagement Meeting	CDC began day long meeting with a panel of senior staff - Debra Lappin. Chair of the CDC Partnership for Prevention Task Force, Rosie Henson Rosie Henson, Deputy Director of the National Center for Chronic Disease Prevention and Health Promotion; and Don Shriber, Director of the CDC Washington Office. Many tribal leaders beginning dialogue with some 150 AI/ANs in attendance. Several other CDC directors and Goal Team Leaders helped to facilitated small group consultation sessions which the body divided into for increased opportunity to hear from AI/AN people and tribal leaders.	CDC recorded in full all comments and recommendations made and incorporated them with additional recommendations received at other Partner and Public Engagement Meetings. These recommendations from the AI/AN people and leader provided needed insights into how the draft goals and objectives could be strengthened to assist CDC in achieving true improvements in people's health and eliminating health disparities throughout the Nation.

Date	Event	In Attendance	Summary
Centers on Medicare and Medicaid Services (CMS)			
March-April	Department Regional Consultations	CMS Central Office Staff; CMS Regional Office Staff	
3/10/2006	Budget Consultation Meetings	CMS Administrator; CMS Budget Office Director; CMS Central Office Tribal Affairs Staff	

Date	Event	In Attendance	Summary
Indian Health Service (IHS)			
July 10-13, 2006	Direct Service Tribes 3rd Annual National Meeting	RADM John O. Agwunobi, Assistant Secretary for Health; RADM Charles Grim, Director, IHS; IHS HQ and Area staff; Tribal Leaders, Health Directors and other Tribal representatives	IHS Chronic Disease Management Initiative; Sovereignty and the Federal obligation for health services; Behavioral health update on Methamphetamines; Update on the HHS "Barriers Study"; Contract Health Services concerns; Health Care Access
October 10-13, 2006	National Indian Health Board (NIHB) Consumer Conference, Denver, Colorado	Tribal Leaders and representatives met with the Director, IHS, IHS HQ and Area staff and other HHS agencies including CMS, SAMHSA and CDC	Discussion focused on issues concerning Medicare/Medicaid, Behavioral Health, Health Promotion/Disease Prevention and a variety of other issues.

Date	Event	In Attendance	Summary
National Institutes of Health (NIH)			
NIH/National Library of Medicine (NLM)			
Dec 6-7, 2006	Tribal Consultation—Native Concepts of Health and Disease, Santa Fe, NM	NLM Director and Senior Staff, 20 Native Americans from varied tribes, University of New Mexico Health Sciences staff	Invitees provided valuable feedback and ideas on a possible NLM exhibit
Oct 25-26, 2006	Tribal Consultation—Native Concepts of Health and Disease, Anchorage, AK	NLM Director and Senior Staff, 20 Alaska Natives from varied Alaska Native tribes and organizations, subject matter experts, Southcentral Foundation staff	Invitees provided valuable feedback and ideas on a possible NLM exhibit
June 22-23, 2006	Tribal Consultation—Native Concepts of Health and Disease, Washington DC (National Museum of the American Indian)	NLM Director and Senior Staff, 15 American Indians from varied tribes, NMAI staff	Invitees discussed topics related to a possible NLM exhibit
NIH/National Center on Minority Health and Health Disparities (NCMHD)			
3/10/2006	Intradepartmental Council on Native American Affairs (ICNAA) National Divisional Tribal Budget Formulation and Consultation Session	NCMHD Director, Dr. John Ruffin and NIH Acting Associate Director for Budget, Mr. Andy Baldus	The NCMHD continued to provide NIH representation to the Intradepartmental Council on Native American Affairs (ICNAA). The NIH representatives at this session shared information on the NIH programmatic activities and the NIH budget formulation process. The result was increased awareness about the NIH program funding and budget process

Date	Event	In Attendance	Summary
Substance Abuse and Mental Health Services Administration (SAMHSA)			
March 16-18, 2006	The Road Home, The National Behavioral Health Conference on Returning Veterans and Their Families, "Restoring Hope and Building Resiliency on March 16-18, 2006 in Washington, DC.	SAMHSA staff; Therapeutic Communities of America staff; Indian veterans.	This meeting was hosted by SAMHSA in partnership with Therapeutic Communities of America. To ensure the participation of tribes and tribal organization SAMHSA provided scholarships to approximately 20 tribes and/or tribal organizations that provide co-occurring mental health and substance use disorders services for Native veterans to attend the conference so that they would have to opportunity to increase their knowledge about federal resources to treatment

Date	Event	In Attendance	Summary
			providers that serve Native veterans who suffer from co occurring disorders, This activity was in direct response to concerns raised regarding services for Indian veterans during the 2006 Regional Consultation Sessions and the DHHS Annual Tribal Consultation Session.
5-Jun-06	Best Practices in Substance Abuse Treatment for American Indians and Alaska Natives Pre-Conference Forum in conjunction with the IHS/SAMHSA National Behavioral Health Conference	SAMHSA and IHS staff; Tribes and Tribal organizations	The Best Practices Forum was attended by SAMHSA tribal grantees and other tribal representatives.
June 5-8, 2006	IHS/SAMHSA National Behavioral Health Conference, *Weaving A Fabric of Strength and Resilience* in San Diego, CA	Tribal Leaders; IHS Program Staff; SAMHSA Program Staff Tribal Alcohol/CD Program Staff and Tribal Community Members; Traditional Healers; State AOD Grant Official; and State Agency Staff SAMHSA speakers included: SAMHSA Acting Deputy Director, Director CSAT, Acting Director CSAP; and Director, Division of Service and Systems Improvement, CMHS	The IHS/SAMHSA National Behavioral Health Conference has become the premiere behavioral health training event for Native people. Fifty-three informational and skill-building workshops were held, including a 10 hour certificated Institute sponsored by SAMHSA's Fetal Alcohol Spectrum Disorder, Center for Excellence and a one-day Pre-Conference, Best Practices in Substance Abuse Treatment for American Indians and Alaska Natives Forum.

REGION-SPECIFIC TRIBAL CONSULTATION

Date	Event	In Attendance	Summary
Centers for Disease Control and Prevention (CDC)			
March 10, March 30, April 5 - 6, April 11-12, April 18-19, April 24-26, May 16-17, 2006	Regions I, II, III, and IV, Region V, Region VI, Region VII, Region VIII, Region IX, Region X, and the 2 Annual HHS National Session	CDC Staff, IGA and HHS national and regional Staff, Tribal leaders, Regional and National Tribal Organizations.	CDC participated in all HHS consultation sessions and provided an update of CDC's implementation of the Tribal Consultation Policy, an accounting of FY 2005 tribal access to CDC resources, pandemic flu activities, and an overview of the guidance for the supplemental funding for pandemic flu as it applies to tribes.

Health Resources and Services Administration (HRSA)			
March 30-31, 2006	Regions I, II, III, IV, VI (Combined) Washington, DC	HRSA/OMHHD staff (Dr. William Robinson, Yvette Fryar, Rita Goodman, Anna Maria Padlan, RaMeicha Cooks)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.
April 25-26, 2006	Region V Green Bay, WI	HRSA/OMHHD staff (RaMeicha Cooks)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.
April 24-25, 2006	Region VI Albuquerque, NM	HRSA/OMHHD staff (Yvette Fryar)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.
April 5-6, 2006	Region VII Sloan, IA	HRSA/OMHHD staff (CAPT Robert Taylor)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.
April 18-19, 2006	Region VIII Rapid City, SD	HRSA/OPR staff (Nick Zucconi)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.
May 2-3, 2006	Region IX Scottsdale, AZ	HRSA/OMHHD staff (Anna Maria Padlan)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.

April 11-12, 2006	Region X Anchorage, AK	HRSA/OPR staff (Dale Bates)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.
May 16-17, 2006	Annual National Tribal Consultation Session Washington, DC	HRSA staff (Dennis William, Deputy Administrator Dr. William Robinson, Yvette Fryar, Rita Goodman, Anna Maria Padlan, RaMeicha Cooks)	The Region discussed several issues with tribes. Policy issues and budget issues that topped the HRSA discussions included health professions recruitment and retention, bioterrorism and emergency preparedness, technical assistance, and health care access for AI/ANs.

Date	Event	In Attendance	Summary
Region II			
March 30-31, 2006	Region II - Regional Consultation Session	Regional Staff, Tribal Leaders, IGA Staff	The Region discussed a number of issues with three tribes. Policy issues and budget issues were discussed.

Date	Event	In Attendance	Summary
Region IV			
3/30-31/06	HHS 2006 Combined Annual Regional Tribal Consultation Session Regions I, II, III, IV, VI	Region IV staff, federally recognized tribes in the region, including in attendance.	Topics of discussion included TANF, pandemic influenza program preparedness efforts, outreach at the local level to bridge the gap in health disparities (OMH), the need for more state agency reps to attend the consultations, a desire for additional assistance in applying for federal grants, and a desire to invite more fiscal intermediaries for Medicare because of issues which arise in the billing process.

Date	Event	In Attendance	Summary
Region IV			
March 30-31, 2006	HHS 2006 Combined Annual Regional Tribal Consultation Session Regions I, II, III, IV, VI	ACF Region IV CC Unit sent one representative; there were no Region IV State or Tribal CC representatives	ACF Region IV Rep provided response to issues re: Tribal TANF from 2005 meeting

Date	Event	In Attendance	Summary
Region IV CMS			

Date	Event	In Attendance	Summary
03-30-06 to 03-31-06	Region IV Regional Consultation Session	Region IV Regional Director; Executive Director, USET; Area Director, IHS Nashville Area Office; Director, Inter-Governmental Affairs; Region IV representatives from ACF, SAMHSA, CDC; Tribal representatives, Region IV: Alabama Poarch Band of Creek Indians	Some agenda topics: Tribal consultation policies were presented by several Operating Divisions, which included SAMHSA, Office of Minority Health, CDC/ADSTR; Pandemic Influenza program preparedness efforts are to include IHS.

Date	Event	In Attendance	Summary
Region V			
April 25-26, 2006	Region V Regional Consultation Session	Tribal Representation MI: American Indian Health and Family Services Bay Mills Hannahville Indian Community Lac Vieux Desert Tribe Little Band of Ottawa Indians* Match-E-Be-Nash-She-	HHS Divisional Cross-Cutting Issues: Funding/Grants: - Tribal sovereignty should be reflected in the funding process (e.g., child welfare, pandemic flu - funds to the states). - More Bemidji-area tribal leadership (elected) representation at National Budget Consultation Session and
		Wish Pottawatomi Pokagon Band of Potawatomi Sault Ste. Marie Tribe of Chippewa Indians MN: Chippewa Tribe Fond do Lac Reservation Mille Lacs Band of Ojibwe Red Lake Upper Sioux Community White Earth WI: Bad River Forrest County Potawatomi	National Budget Forum. - Accessibility to grants severely limited; parity for smaller tribes (smaller tribes do not meet numbers guidelines). Set-asides - tribes should not have to compete with states and counties. - Get tribal input toward grant criteria development for future funding for tribes, utilize existing needs/issues. - Growth in appropriations for Bemidji-area/funding - tribes are unique, not a special needs population/minority. Consultation: ensure consultation with tribes, not councils/consortia.

Date	Event	In Attendance	Summary
		Gerald L. Ignace Indian Health Center, Inc Ho-Chunk Nation Lac Courte Oreilles Tribe* Lac du Flambeau Tribe Menominee Indian Tribe of Wisconsin Midwest Alliance of Sovereign Tribes Oneida Nation* Red Cliff Band of Lake Superior Chippewa* Sokaogon Chippewa Community Stockbridge-Munsee Community*	ACF: - ICWA Compliance. - Customary adoptions within tribal courts without termination of parental rights impact social security benefits. Ensure eligible state and federal subsidies. - Funding to advocate for increasing number of juveniles processed into system. - Lack of direct IV-E funding to Tribes; continued frustration over efforts to establish State-Tribal IV-E agreements and the ability to make State Title IV-E funds available to Tribes.
		St. Croix Chippewa Indians of Wisconsin Forest County Potawatomi State Representation: Michigan Dept of Community Health Michigan Dept of Human Services Minnesota Dept of Health Minnesota Dept of Human Services Wisconsin Dept of Health & Family Services (Secretary) Wisconsin Dept of Workforce Development Wisconsin Governor's Office	- ACF Reorganization (Child Care Bureau). Tribes should have been consulted about the reorganization before the decision was made. - Changes and budget cuts in Head Start programs - Lack of public input time for new TANF regulations. Child Welfare Targeted Case Management funding cuts. - Additional funding sources for Child Welfare programs. - Red Lake human services concerns: all focus on physical health and substance abuse; mental health services for youth and t/a are needed
		US DHHS National & Regional Representation: IGA*, IHS*, ACF*, ORHA*, SAMHSA*, ATSDR*, AoA, CDC, CMS, FDA, HRSA, OCR, OGC, OPHEP [*Leadership]	AOA: - Inadequate funding for Older Americans Act (OAA) programs, including Titles III, V, VI, VII and Family Caregiving. Need supportive dollars to take care of elders, keep them independent - Long term care support. - Elder abuse and protection. ATSDR: - Radon and Meth clean-up funding. [Potential resources noted - state health departments may be resource for exposure and investigation assistance; ACF's ANA has competitive regulatory grants for the environment; and EPA has a Radon Risk Reduction in Tribal Indoor Radon Grants programs.]

Date	Event	In Attendance	Summary
			CDC: - CDC's technical reporting requirements are not good fit for Bemidji-area smaller tribes (differ from SW tribes). - Grants around chronic disease prevention/wellness (e.g., diabetes, depression). Cost of pan flu vaccine (estimate) for tribal planning/budgeting. [CDC subsequently addressed.]
			- Bioterrorism/Emergency Preparedness funds are given to states; states not given enough time to develop plans for tribal input. CMS (7 issues outlined in Oct. 8 TTAG letter to Dr. McClellan): - Medicare-like rates. Include Critical Access Hospitals (CAH) in the regulations. Medicaid Administrative Match - Additional training on Part D (Tribes believe some additional funds can be captured through MMA). - Impact of Deficit Reduction Act (DRA) case management changes on mental health services, especially post treatment and in long-term care. - CMS should mandate that States consult with Tribes on the implementation of the DRA provisions.
			HRSA: - Community Health Centers (CHC) funding to serve tribal members only, no "open door" policy for everyone. - CHC's not enough to serve Urban Indians; culturally-sensitive care needed. - Bioterrorism/Emergency Preparedness funds are given to states; states not given enough time to develop plans for tribal input.
			IHS: - Proposed elimination of Urban Indian Healthcare Program. Bemidji-area lowest funded service area/long waits already. Tribal members will return to the reservation for care and will be additional burden on already

Date	Event	In Attendance	Summary
			overwhelmed system. Subsequently, provide additional tribal health care funds. - Indirect cost rates for tribes are not working; affecting funding sources. - Medicare-like rates - do not need critical care hospital rates. - Electronic health records - implement at all IHS and tribal sites - seriously under-funded; important for third party billing and patient safety.
			- Contract Health Services (CHS) not working; change regulations/criteria to respond to real needs of recipients. - "CHS and Chronic Care Model" - shift funds to prevention (loss of life/limb not acceptable)
			OPHEP: - Tribes lack ability and support for pandemic flu preparedness. Tribal involvement in state/municipal government planning/integration. OPHS: Funding to attend National Pan Flu Summit. - Bemidji-area representative needed for OMH AI/AN Health Research Advisory Council. [Two tribal leaders selected for the May 18, 2006 meeting (primary/alternate). - Same issue on Title X as with HRSA 330 grants - must be able to define their "own" "community" (OPA).
			SAMHSA: - Methamphetamine Issues: Interaction between child welfare and methamphetamine abuse/dependence; prevention services needed/must be proactive before problem occurs; increasing use/abuse/manufacture; resources for meth lab clean-up. Suicide Prevention: more emphasis on prevention vs. response; explore the establishment of set-asides for tribal governments. - Eliminate barriers for grant access – e.g., small geographic

Date	Event	In Attendance	Summary
			areas under 1,000 tribal members. Remove "open to all" requirement and focus on tribes. Tribes may lose funds due to administrative costs if part of a consortium that applies for a grant. - Develop prevention grants related to chronic diseases (e.g., those with diabetes or cardiac problems who develop depression and/or abuse substances).
			- Examine any specific models that are identified in grants for cultural appropriateness. Mental Health Issues: Funding for children and adults; culturally relevant – recognize traditional healing. Tribes experiencing increased child mental illness dual diagnosis and need 3-6 months treatment, but lack funding; limited services available. Parents need help. Increase in number of children with mental illness, domino effect - cutting, self mutilation - bipolar, schizophrenia, poly-substance abuse. -Increased tribal access as providers within the "Access to Recovery" funds. - T/A and resources for Red Lake's children's mental health services.

Date	Event	In Attendance	Summary
Region VI			
April 24-26, 2006	Region VI Regional Consultation Session	**HHS**: Region VI Staff, HHS HQ IGA, IHS HQ, HRSA HQ, SAMHSA HQ, ACF, AOA, ATSDR/EPA, CDC, CMS, HRSA, OCR, OGC, ORD, RHA, SAMHSA, IHS Albuquerque Area, IHS Navajo Area, IHS Oklahoma City Area, IHS Santa Fe Service area. **State**: Oklahoma State Department of Health, New Mexico Aging and Long Term Services Department, New Mexico Children, Youth and Families	Topics of discussion included first year evaluation of the tribal consultation policy; follow-up to 2005 tribal priorities; HHS division consultation plan revisions; CDC, IHS, Organizational and State Pandemic Influenza Preparedness, interstate and foreign quarantine and its impact on Indian Country; TTAG report; MMA and Medicare prescription drug coverage; across state border Medicaid issues; federal supply schedule issues; state waiver and demonstration programs; and state Medicaid reports. Tribal priorities presented

Date	Event	In Attendance	Summary
		Department, New Mexico Department of Health, New Mexico Human Services Department, New Mexico Indian Affairs Department, Oklahoma Health Department, Texas Department of State Health Services. Tribes: Absentee Shawnee,	included consideration for plan to track funds and population in urban areas; Title V reauthorization; reauthorization of the Indian Health Care Improvement Act; lack of overall funding; lack of tribal involvement in decision making; appreciative of increased communication between HHS and tribes; impact of the MMA 2003 and the Deficit
		Alabama-Quassarte Tribal Town, Alabama -Coushatta Tribe of Texas, Alamo Navajo School	Reduction Act of 2005 on Indian health care systems; recommend that tribes be able to regulate own health and safety
		Board, Inc., All Indian Pueblo Council, C-A Tribes of Oklahoma, Caddo Nation, Canancito Band of Navajos, Cherokee Nation of Oklahoma, Cheyenne and Arapaho Tribes of	standards; technical assistance needed for grant writing; establish task force to deal with meth use; recruitment and retention of medical staff; lack of dental care for adults and elderly; and health care needs of urban Indians.
		Oklahoma, Chickasaw Nation, Chickasaw Nation Health System, Choctaw Nation, Choctaw Nation Health Services Authority, Choctaw Nation of Oklahoma, Citizen Potawatomi Nation Health Services, Delaware Tribe of Oklahoma, Eight Northern Indian Pueblos Council, Inc, Iowa Tribe of Oklahoma,	
		Isleta Pueblo, Jemez Pueblo, Jena Band of Choctaw Indians, Jicarilla Apache Nation, Kaw Nation, Kickapoo Traditional Tribe of Texas, Laguna Pueblo, Mescalero Apache Tribe, Muskogee (Creek) Nation, Navajo Division of Health, Navajo Nation, Navajo Nation Department of Behavioral Health Services,	

Date	Event	In Attendance	Summary
		Navajo Nation- NAAA, Osage Nation, Pawnee Nation of Oklahoma, Ponca Tribe of Oklahoma, Pueblo of Acoma, Pueblo of Isleta, Pueblo of Jemez, Pueblo of Laguna, Pueblo of Picuris, Pueblo of San Felipe, Pueblo of San Ildefonso, Pueblo of Sandia, Pueblo of Zia, Sac and Fox Nation of Oklahoma, San Felipe Family Services,	
		Santa Clara Pueblo, Seminole Nation, The Chickasaw Nation, United South & Eastern Tribes, Inc., Ysleta Del Sun Pueblo, and Zuni Tribe. Org: ACL Hospital, Albuquerque Area Indian Health Board, Bearskin Healthcare & Wellness Center, Center for Native American Health University of New Mexico Health Sciences Center, Clinton Indian Hospital, Comanche Nation	
		Indian Child Welfare, Crownpoint Healthcare Facility- Navajo, Hastings Indian Medical Center, IHS Hospital- San Fidel, IHS Santa Fe Service Unit, Indian Health Care Resource Center of Tulsa, IHS Crownpoint Service Unit, IHS-Okmulgee, Lawton Indian Hospital, LifeMasters Supported Selfcare,	
		National Indian Childcare Association, Northeastern Tribal Health System, Oklahoma City Area Inter-Tribal	

Date	Event	In Attendance	Summary
		Health Board, Oklahoma Health Care Authority, Southwest Center for Public Health Preparedness, University of Oklahoma Health Sciences Center, Taos-Picuris SU & Santa Fe SU Health Board, Trailblazer Health, Wewoka Indian Health Center.	
3/30-31/06	USET Tribal Consultation Session	HHS CO and RO staff from Regions I, II, III, IV, and VI. USET tribal representatives	USET tribes presented a variety of issues. Acting RD Perkins followed up on child care and Head Start issues raised by the Alabama-Coushatta

Date	Event	In Attendance	Summary
Region VII			
April 5-6, 2006	Region 7 Annual Tribal Consultation	ACF, AOA, ATSDR, CDC,CMS, OCR, OPHS,OS Intergovernmental Affairs, ORD, HRSA, IHS, IHS Aberdeen, IHS Oklahoma, PSC, SAMHSA, Kansas Division of Health,	Program/Budget Issues, Meth and Related Issues, Services(Access, Financing/Reimbursement), Aging, Dialysis, Emergency Response/Pandemic Flu, Improving Consultation/Support for Tribes at HHS/HQ, Children and Families
		Nebraska Dept of Health and Human Services, Iowa Dept of Public Health, Kickapoo Tribe in Kansas, Ponca Tribe of Nebraska, Omaha Tribe of Nebraska, Prairie Band Potawatomi Nation, Winnebago Tribe of Nebraska	

Date	Event	In Attendance	Summary
Region X			
April 11-12, 2006	Region 10 Annual Consultation Session	Region 10 Staff (ORD, OPHS, ATSDR, CMS, ACF, HRSA, OGC), IHS, SAMHSA, CDC, Federally Recognized Tribes in the region, including Norton Sound	Agenda items included: Summary of Tribal Priorities & Concerns, HHS Tribal Consultation Policy, Presentations from HRSA, SAMHSA, CMS (Medicare Part D & Medicaid), ACF, IHS, CDC (Pan Flu).
		Health Corporation, Southeast Alaska Regional Health Corporation, Southcentral Foundation, Shoalwater Bay Indian Tribe, KANA, Yellowhark Tribal Health Center,	

Date	Event	In Attendance	Summary
		Suquamish Tribe, Skokomish Indian Tribe, Alaska Native Tribal Health Consortium, Colville Confederated Tribes, Confederated Tribes of Siletz Indians, Jamestown S'Klallam Tribe, Tanana Chiefs Conference, Port Gamble S'Klallam Tribe, Nimiipuu Health, Lower Elwha Klallam Tribe, Mt Sanford Tribal Consortium, Puyallup Tribes, Bristol Bay Native Association,	
		Chugachmiut, Confederated Tribes of the Umatilla Indian Reservation, Lummi Nation, Council of Athabascan Tribal Governments, Southcentral Foundation, and Beneway Medical Center.	

TRIBAL DELEGATION MEETINGS

During 2006, HHS continued an open door policy for Tribes and Tribal Organizations. HHS Senior Leaders and program staff met at the request of Tribes to discuss issues of concern.

DIVISION TRIBAL DELEGATION MEETINGS

Date	Event	In Attendance	Summary
Administration for Children and Families (ACF)			
ACF/Administration for Native Americans (ANA)			
1/31/2006	Quinault Indian Nation - Taholah, WA	ANA Commissioner Quanah Stamps; met with Chair and Vice Chair.	Discussed Economic Development activities, discussed Pacific Northwest Tribal issues and conducted a site visit of the Quinault Community businesses.
3/15/2006	Washoe Tribe of Nevada and California - Reno, NV	ANA Commissioner Stamps; Brian Wallace, Chairman; Max Kalhammer, Tribal Planner; Marie Barry, Environmental Director.	Discussion of two ANA Grant projects: "A Socio-economic Profile of the Washoe People" and "Washoe Environmental Regulatory Enhancement Project." Discussion of recent impact evaluation.
3/28/2006	Cherokee Nation - Catoosa, OK	ANA Commissioner Quanah Stamps; Principal Chief Chad Smith.	Discussed Tribal/ANA grants, visited self-help community projects, and discussed Language preservation activities.

Date	Event	In Attendance	Summary
3/30/2006	Pawnee Nation of Oklahoma Pawnee, OK	ANA Commissioner Quanah Stamps; Chairman Ron Rice; Business Council Members; Tribal Council Officers; ANA Project staff.	Meeting with Chairman and Council Members, discussion of ANA Grant Projects, economic development activities and Language immersion. Toured Language lab and after school Language immersion activity.
4/27/2006	Red Lake Chippewa Reservation - Red Lake, MN	ANA Commissioner Quanah Stamps; Chairman Floyd Jourdain, Jr.; Secretary Judy Roy; Treasurer Darrell Seki; Representatives from four Red Lake Communities: Little Rock, Ponemah, Redby, and Red Lake.	Meeting with the Tribal Council to discuss ANA projects and the healing of the Red Lake Communities. Presentation of gift for the community. Site visit to the community centers and Pow Wow grounds rehabilitated by the Tribal Civilian Community Corps. (TCCC) as part of the ANA Youth Grant.
6/7/2006	Lac Courte Oreilles Band of Lake Superior Chippewa Indians - Hayward, WI	ANA Commissioner Quanah Stamps; Tribal Council Members.	Discussed ANA Grant with the Tribal Council and Project Director. Toured Tribal Offices and local restaurant to see wood work completed as part of ANA Grant, the Chippewa Wood Crafters work studio and new work studio site under renovation.
8/21/2006	Native Village of Kasan - Kasan, AK	ANA Commissioner Quanah Stamps; Assistant Administrator Lance Twitchel; Master Carver; Village Elder.	Discussed ANA grant project and visited with village elders. Discussed economic development and language preservation activities. Toured the healing heart totem pole project and met with community members.
8/23/2006	Native Village of Port Graham - Port Graham, AK	ANA Commissioner Stamps; Tribal Chief Patrick Norman; Fran Norman.	Discussion of two ANA grant projects and economic development activities. Toured fisheries and ponds.
8/24/2006	Seldovia Village Tribe - Seldovia, AK	ANA Commissioner Quanah Stamps; Tribal Chief Don Kashevaroff, Executive Director Crystal Collier.	Discussed ANA grant project and economic development activities with Tribal Chief, Executive Director and community members. Toured Seldovia community businesses and the newly renovated conference center.
ACF/Family and Youth Services Bureau (FYSB)			
5/15/2006	Family Violence Prevention Services (FVPS) Tribal Meeting in Scottsdale, AZ	Tribal grantees and FVPS.	Family Violence staff and Director met with representatives from grantees across Indian Country. Gathered input and recommendations on issues facing Tribes with regard to family violence and its prevention.
ACF/Office of Child Support Enforcement (OCSE)			

Date	Event	In Attendance	Summary
Oct, 05; Mar, 06; Jul, 06;	1) Sisseton/Wahpeton Oyate, ND; 2) Acoma Pueblo, NM; 3) Navajo Nation, Penobscot Nation, ME, and Fort Belknap, MT; 4) Navajo Nation, AZ	1) OCSE, Tribal IV-D Grantee; 2) OCSE, potential Tribal IV-D Grantee; 3) OCSE Tribal IV-D Grantee, OCSE-Tribal IV-D Grantee, State of Maine IV-D Agency, ACF Region I; OCSE, potential Tribal IV-D Grantee; 4) OCSE, Tribal IV-D Grantee.	1) Site Visit; 2) Training and Technical Assistance (T/TA) Visit; 3) Site Visit, Site Visit and T/TA Visit; 4) Monitoring Site Visit.
ACF/Office of Family Assistance (OFA)			
11/30/2005	Meeting with representatives from the Pueblo of Acoma	Federal: Division of Tribal TANF Management and ACF Region VI. Staff Tribal: Gregg P. Shutiva, 1st Lieutenant Governor, Tony B. Chino II, Tribal Secretary, and Melissa R. Gordon, (ICWA) Coordinator from Acoma Pueblo.	Consultation on Federal TANF requirements and issues pertaining to the development of a TANF plan.
2/3/2006	Consultation with TANF Administrator for the Robinson Rancheria TANF Program	Federal: OFA Staff Tribal: Acting Director of the Robinson Rancheria TANF program.	Discussed a range of issues, challenges, and recent actions taken by the grantee to improve program performance. Technical assistance was provided in response to the issues raised.
2/3/2006	Consultation with the Blackfeet Nation and Montana	OFA Central Office and ACF Regional Office-Denver; Tribal: the Blackfeet Council, the Blackfeet TANF Program; State: Montana Governor's Office, the Montana TANF program, and two Montana State legislative members.	Participated in a two hour conference call where we provided information about the Deficit Reduction Act of 2005 and discussed available options for dealing with a funding shortfall in the Blackfeet TANF program.
6/8/2006	Conference call with Lummi Tribe representatives.	Federal: Ray Apodaca, Judy Ogliore - ACF Reg. X; Tribal: representatives of the Tribal council and administrative staff.	Possible submission of a TANF plan.
6/22/2006	Meeting with the Tribal Administrator of the Bad River Tribe	Federal: Ray Apodaca, Elaine Richman - OFA Tribal: Bad River Tribal administration staff.	Changes and issues relating to their TANF program.
7/3/2006	Conference call with representatives of the three TANF grantees in Riverside County, California, i.e., Torres Martinez, Soboba, and	Federal: Ray Apodaca - OFA, Rick Wever and Julie Fong - ACF Reg. IX; Tribal: TANF program and Tribal Administrators of the three respective programs and Tribes.	Service areas and population distribution issues in the TANF programs.

Date	Event	In Attendance	Summary
	Morongo		
7/18/2006	Meeting with Spokane Tribe staff	Federal: Ray Apodaca - OFA, Greg Kenyon - ACF Office of Financial Service/Division of Grants Management; Tribal: Luanne Ferguson and Greg Wyncoop from Spokane Tribe.	Budget reporting requirements for the TANF program and 477 plan.
8/10/2006	Meeting with the director of the Morongo TANF program and staff	Federal: Ray Apodaca - OFA; Tribal: Jim Henry - Director Morongo TANF Program and staff.	Technical Assistance (TA) and discussion of expansion plans.
8/17/2006	Conference call with Winnebago TANF program staff	Federal: Ray Apodaca - OFA; Tribal: Matthew Cleveland and Regina Littlebeaver - Winnebago TANF staff.	TA and discussion of expansion plans.
8/24/2006	Conference call with South Puget Inter-tribal Planning Agency TANF program staff	Federal: Ray Apodaca - OFA, Judy Ogliore - ACF Reg. X; Tribal: Executive Director and staff of the SPIPA program.	TA relating to program activities and administration of the program.
8/25/2006	Conference call with Navajo Nation TANF staff	Federal: Ray Apodaca - OFA and Rick Wever - ACF Reg. IX; Tribal: Anthony Dineyazhe and Roxanne Gorman from Navajo TANF program.	TA relating to their service area and eligibility standards.
9/14/2006	Meeting with representatives of the Skokomish Tribe (a participant in the South Puget Inter-Tribal Planning Agency consortium and TANF program)	Federal: Ray Apodaca, Joanne Fradkin, Tonya Taylor - OFA; Tribal: Skokomish Tribal Chairman and staff.	TA relating the program operation and possible plans to separate and begin their own TANF program.
9/14/2006	Meeting with South Puget Inter-Tribal Planning Agency (SPIPA) - Tribal Consortium	Federal: Ray Apodaca, DTTM and Elaine Richman, State Policy - OFA; Tribal: Carol Cordova, SPIPA Program Coordinator, Geene Felix, SPIPA TANF Director, Sandra Cole, SPIPA Chief Financial Officer.	Tribal Temporary Assistance for Needy Families (TTANF) TA to consortium and TANF program staff related to work activities, support services, plan amendments/renewal and related issues.

Date	Event	In Attendance	Summary
Agency for Healthcare Research and Quality (AHRQ)			

Date	Event	In Attendance	Summary
5/19/2006	Departmental Tribal Advisory Council on Health Research	Principals from participating OPDIVs/STAFFDIVs & members of Advisory Council representing tribes and tribal organizations	This was the first meeting of the Council. Emphasis was on orientation & getting organized.

Date	Event	In Attendance	Summary
Administration on Aging (AoA)			
Mar. 1, 2006	Lower Elwha Klallam Tribe	Yvonne Jackson, AoA, Lower Elwha Klallam Vice Chairman and Executive Director	Meeting to discuss Tribal aging population
Mar. 15, 2006	Midwest Alliance of Sovereign Tribes	Yvonne Jackson, AoA, Tribal representatives from MN, WI, MI, and IA.	Meeting with M.A.S.T. membership to provide an update on Indian aging issues.
May. 3, 2006	Inter-Tribal Council of Arizona	Yvonne Jackson, AoA and Lee Begay, ITCA	Meeting to discuss OAA reauthorization priorities.
May. 3, 2006	Denakkanagga	Yvonne Jackson, AoA and Tribal representatives	Meeting to discuss OAA reauthorization priorities.
Mar. 17, 2006	Navajo Delegation	Yvonne Jackson, AoA and Navajo Nation representatives	Meeting to discuss need for another nursing home on the Navajo reservation.
Jun. 29, 2006	Central Council Tlingit and Haida Indian Tribes	Yvonne Jackson, AoA and representatives from Central Council Tlingit and Haida Indian Tribes	Site visit and meeting to discuss issues faced by elders living in and around Juneau.
Sept. 27, 2006	Cherokee Nation	Yvonne Jackson, AoA and representatives from Cherokee Nation	Site visit and meeting to discuss caregiver issues and issues faced by Cherokee elders.

Date	Event	In Attendance	Summary
Agency for Toxic Substances and Disease Registry (ATSDR)			
January, 06	Hopi Tribal Consultation	Director, Hopi EPA ATSDR Attendees: Division of Toxicology and Environmental. Medicine and Division of Regional Operations	The consultation was related to a planned chemical evaluation for toxaphene in sheep dip vats. This was at the request of the Hopi.
March, 2006	Native Village of Port Graham and Native Village of Seldovia	NVPG – Tribal Chair and Council NV Seldovia – Environmental Manager ATSDR Attendees: Division of Health Assessment and Consultation; Division of Regional Operations; Office of Tribal Affairs	At the request of the village councils, ATSDR representatives met in consultation to discuss outcomes of an evaluation of the public health effects from harvesting of traditional foods from the Cook Inlet.

June, 2006	10 Tribes affected by the Tar Creek, OK Superfund Site	Tribes in attendance: Ottawa, Cherokee Nation; Wyandotte Nation and Peoria. ATSDR Attendees: Division of Health Assessment and Consultation; Division of Regional Operations; Office of Tribal Affairs	This consultation session provided an opportunity for the agency to present a plan for various public health activities to address concerns from the tribes about environmental exposures and for the tribes to discuss this with the agency and for the group to reach agreement on the plan.

Date	Event	In Attendance	Summary
Centers for Medicare and Medicaid Services (CMS)			
'12/15/2006	Meeting with Navajo Nation, Albuquerque, NM	Navajo Nation leadership: vice president, Executive Director Division of Health; AZ, UT, & NM Medicaid Directors/staff; CMS Central Office & Regional Staff from VI, VIII & IX	Discuss Medicaid determination and redetermination and cross state boarder issues
	Site visit to Navajo Nation and health facilities	Nation Leadership and Division of Health; CMS Medicaid Staff; IHS Area Office Staff; Director & Business Office Staff of Fort Defiance Indian Hospital & Gallup Indian Medical Center	Purpose of trip was to gain a first hand understanding of Indian health system. Site visits to facilities, overview of Nation programs, presentations on concerns and issues.

Date	Event	In Attendance	Summary
Health Resources and Services Administration (HRSA)			
No date given	Performance Review	Region V OPR staff Northwestern Mental Health Center, Inc.	Region V conducted a performance review of Northwestern Mental Health Center, Inc. in Crookston, MN. This grantee receives a rural health development grant from HRSA. Northwestern is part of the Mahnomen Mental Health Consortium whose client population is 20% American Indians who reside on the White Earth Indian reservation.

Date	Event	In Attendance	Summary
No date given	Performance Review	Region X OPR staff, Norton Sound Health Corporation	The Norton Sound Health Corporation (NSHC), founded in 1970, is an Alaskan chartered corporation whose mission is to provide comprehensive health care to residents and visitors in the Bering Strait region of northwest Alaska. NSHC provides comprehensive primary medical, obstetrical, behavioral, preventive and oral health care services in Nome at the Norton Sound Regional Hospital (NSRH) and in 15 villages scattered on the coast and islands of the Bering Sea. NSHC has received HRSA health centers funds since September 2002. NSHC receives a significant proportion of its operational funds from the IHS to provide care to Alaskan Natives.
No date given	Performance Review	Region X OPR staff, Seldovia Village Tribe	The Seldovia Village Tribe (SVT), is a federally recognized tribal government, has operated health care programs since 1976, initially as a 638 federal subcontractor with the IHS, and since 1993, as a co-signer of the Alaska Tribal Health Compact. In fall 2001, SVT began offering primary care services to tribal members and IHS beneficiaries residing in Homer, Alaska.
No date given	Performance Review	Region VII OPR staff, The Utah Radiation Exposure and Screening Education Program (URESEP)	URESEP was funded by a grant from HRSA in 2002 and provides residents of Utah with comprehensive education, outreach, screening and referral services in a culturally appropriate and sensitive manner for the downwind population. URESEP provides outreach and public education related to radiogenic diseases. Once eligibility is determined, URESEP provides comprehensive services to clinic users including: health education, case management, medical and occupational health history, complete physical examination, appropriate medical tests, such as pulmonary function screening,

Date	Event	In Attendance	Summary
			chest x-ray, electrocardiogram, blood tests, Pap test for women, and chest computerized tomography (CT). Letters of findings and recommendations are sent to the client and to the client's primary care physician.
No date given	Performance Review	Region IX OPR staff, Canyonlands Community Health Care (CCHC)	Forty-nine percent of their users are Native American (2005 UDS) - Navaho and other tribes. CCHC has nine sites that stretch from the northeast border with Nevada to the eastern border with New Mexico. Page is on the northern border with Utah. It is approximately a 4 hour drive from the sites near the Nevada border to Page, and a 7 hour drive from Page to the southern clinics close to the New Mexico border. CCHC serves Medicaid recipients from 4 states, Arizona, Nevada, Utah, and New Mexico. Each state has different Medicaid rules and regulations. CCHC has one very successful Native American outreach worker and is trying to find funds to hire another. During the performance review, the team looked at average Hemoglobin A1C and focused on the Native Americans as have a considerably higher rate of diabetes than other ethnic groups. The review team recommended that CCHC consider verbal recordings in the Navajo language of the information contained in written health education literature. Patients may listen to the information on a headset while waiting for services. This option was chosen because Navaho is a spoken, not written language.
No date given	Performance Review	Region VII OPR staff, Turtle Mountain Community College	The Turtle Mountain Community College has a HRSA grant for a Health Careers Opportunity Program (HCOP). In this HCOP summer program, 60 high school and community college students are given course work in science, math, language and study skills.

Date	Event	In Attendance	Summary
			They are exposed to a variety of health professions and have the opportunity to participate in internships. Through achievement testing before and after the summer session, the program has shown the great benefit of this
			summer academic opportunity for students who are interested in health careers. The students are supported on stipends through the summer and are given tutoring and mentoring as well as help in applying to health professions programs and obtaining financial aid.
No date given	Performance Review	Region VII - Utah Navajo Health System, Inc., (UNHS)	UNHS operates a community health center and a Radiation Exposure Screening and Education Program in Montezuma Creek, Utah. Using HRSA funds since 2000, UNHS has expanded from one site in Montezuma Creek to full time clinic facilities in Blanding and Navajo Mountain, and part time clinic facilities in Bluff, Aneth (a Bureau of Indian Affairs school). As of July 31, 2005 UNHS served nearly 8,000 unduplicated users of whom approximately 70 percent were Navajo and 25 percent Caucasian. UNHS offers a comprehensive continuum of services including: primary, specialty, obstetrical and gynecological medical care; dental care, preventive and behavioral health services, and pharmacy services. They also provide a variety of enabling services including case management, eligibility assistance, health education, translation, outreach, and transportation.
Ongoing throughout 2006	HRSA/BPHC staff, Montana Primary Care Association, and various Tribal organizations	Section 330 Funding Opportunities	BPHC staff provided information and clarification regarding reimbursement policy interpretation for tribes with Section 330 funding and similarly clarified meeting with the Montana Primary Care Association (MPCA)

Date	Event	In Attendance	Summary
			and tribal representatives interested in applying for Section 330 funding opportunities in September 2004. During FY 2005, BPHC staff worked jointly with CMS and IHS to respond to tribal questions
			initially raised at this meeting. The continual collaboration with BPHC and IHS were ongoing for FY 2006, and are expected to continue for FY 2007 and FY 2008.
Ongoing throughout 2006	HRSA/BPHC staff, National/State organizations, and various Tribal organizations	Technical assistance training activities on the Section 330 application process	Staff from the HRSA/BPHC participated in numerous meetings for technical assistance and training that were attended by tribal organizations. These included: Training events sponsored by the national and State organizations. National pre application conference calls for all of the announced competitive opportunities to provide technical assistance on the requirements of the program and expectations for successful applicants. Responding to numerous requests for additional information on HRSA/BPHC programs, requirements and expectations. Staff from HRSA/BPHC also participated on a site visit to tribal groups to discuss the requirements for the Health Center Program.

Date	Event	In Attendance	Summary
Indian Health Service (IHS)			
6/19/2006	Tuba City Regional Health Care Corporation - Navajo Nation	Navajo Area Office IT Representatives, Tuba City Regional Health Care Corporation Representatives, Office of Information Technology Representatives	Discussed Indian Health Service Office of Information Technology Services for HQ Information Technology Managed Funds. Discussion centered on what IT Functions and services are available to Tuba City Regional Health Care Corporation for their Information Technology HQ Managed Funds.

Date	Event	In Attendance	Summary
7/31/2006	Tuba City Regional Health Care Corporation - Navajo Nation	Navajo Area Office IT Representatives, Tuba City Regional Health Care Corporation Representatives, Office of Information Technology Representatives	Discussed Indian Health Service Office of Information Technology Services for HQ Information Technology Managed Funds. Discussion centered on what IT Functions and services are available to Tuba City Regional Health Care Corporation for their Information Technology HQ Managed Funds.
10/30/2006	Tuba City Regional Health Care Corporation - Navajo Nation	Navajo Area Office IT Representatives, Tuba City Regional Health Care Corporation Representatives, Office of Information Technology Representatives	Discuss IT issues of support from both the Area and HQ Level.
October 1, 2005 - September 30, 2006	43 Tribal Delegation Meetings conducted with Director, IHS and/or designated Deputy Director	Director, IHS and Key IHS HQ and Area Staff	Meetings with the Director requested by Tribal Leaders to discuss issues of concern; these generally fall within the following categories: Contract Health Services Funding; Funding for Facilities Construction; Grants; EHR

Date	Event	In Attendance	Summary
National Institutes of Health (NIH)			
NIH/National Heart, Lung, and Blood Institute (NHLBI)			
Item 3 03/21/06 02/28/06	NHLBI's Integrated Risk Factor Booklet for American Indians and Alaska Natives (materials development and outreach) - Conference Calls	IHS Aberdeen Area Office – Ellie Zephier – Lead Nutritionist, 12 tribes are part of the Aberdeen Area. Chickasaw Nation – Pamela Aguilar – Community Health Representative (CHR) Project Coordinator Southcentral Foundation – Dr. Ted Mala -Director of Tribal Relations, Alaska Native Medical Center, Director of Traditional Healing. Southcentral Foundation is an Alaska Native-owned healthcare organization serving Alaska Native and American Indian people living in Anchorage , the	Discussion to gain input from tribal communities on the development of integrated cardiovascular risk factor booklets and to develop opportunities to test the acceptability (format, graphics, and content) and ease of use of the materials by tribal organization representatives. Activity focuses on cardiovascular health disparities in AI/AN communities. Results: A majority of participants chose to have one integrated risk factor booklet (combine 4 booklets into one) however, they prefer to have 2 versions – AI and AN. Many offered to assist with review and comment during development, and to provide photos from the field.

Date	Event	In Attendance	Summary
		Mat-Su Valley and 60 rural villages in the Anchorage Service Unit. Minnesota State Health Department - Elizabeth A. Gardner, M.A. Community Health Planner, Minnesota Heart Disease and Stroke Prevention Unit Center for Health – Partners with 12 tribes in MN, approximately 4 tribes	
		responded with comments: White Earth, Red Lake, Fond du Lac, Leech Lake. Donald Silva - RN-Diabetes Program Coordinator -North American Indian Center of Boston (urban Indian health center – provides services to American Indians living in Boston.	
NIH/National Library of Medicine (NLM)			
5-Dec-06	Meeting, Jemez Pueblo, NM	NLM Director and Senior Staff, Jemez Pueblo Indian cultural and health staff, University of New Mexico Health Sciences staff	Jemez Pueblo staff provided valuable insights on Jemez culture and health topics. Jemez Pueblo staff were asked to brief NLM on culture and health topics
4-Dec-06	Meeting, Acoma Pueblo, NM	NLM Director and Senior Staff, Acoma Pueblo Indian staff, University of New Mexico Health Sciences staff	Acoma Pueblo staff provided valuable insights on Acoma culture and health topics. Acoma Pueblo staff were asked to brief NLM on culture and health topics
23-Oct-06	Meeting, Tlingit-Haida Tribe, Juneau, AK	NLM Associate Director and Senior Staff, Tlingit-Haida cultural and health staff, Alaska State legislative staff	Tlingit-Haida staff provided valuable insights on tribal culture and health topics. Tlingit-Haida staff were asked to brief NLM on culture and health topics
January 25-27, 2006 and November 15-17, 2006	Meetings, Chickasaw Nation, Ada, OK	NLM staff, Governor of the Chickasaw Nation, Carl Albert Health Center administrators and staff	Participants discussed and planned for the creation of a health information center for the health center. NLM staff demonstrated health information resources; health center staff developed implementation plan; Governor gave approval
NIH/National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)			

Date	Event	In Attendance	Summary
Nov.7-8 at 4 month annual intervals	Meeting with Tribal Leaders Diabetes Committee (TLDC)	NIDDK representatives: Larry Agodoa and Sanford Garfield	NIDDK meet with the TLDC Tribal Leaders representing the 12 HIS Tribal Regions to discuss the Diabetes based science Education in Tribal Schools (DETS)

Date	Event	In Attendance	Summary
Substance Abuse and Mental Health Services Administration (SAMHSA)			
5-Jan-06	Meeting with Cheyenne River Sioux Tribe at SAMHSA Offices	SAMHSA staff, NCAI Government Affairs Director and Cheyenne River tribal members	Issues discussed at this meeting included the Cheyenne River Youth Project Teen Recreation Center Project and possible SAMHSA funding.
21-Apr-06	Meeting with Fort Belknap Tribe at SAMHA Offices	SAMHSA's Director, Center for Substance Abuse Treatment, tribal leadership and tribal behavioral health staff and SAMHSA staff.	Issues discussed at this meeting included SAMHSA funding processes and the Tribe's current behavioral health activities.
21-Aug-06	Meeting with Choctaw Nation in Durant, Oklahoma	SAMHSA's Tribal Specialist, Office of Policy, Planning and Budget, and OMH Associate Director for Planning and Policy Coordination, Tribal leadership, tribal behavioral health staff and tribal law enforcement	The purpose of this meeting was to discuss the HHS Indian Country Methamphetamine Initiative and the Choctaw Nation's role as a treatment and recovery site.
22-Aug-06	Meeting with Winnebago Tribe in Winnebago, Nebraska	SAMHSA's Tribal Specialist, Office of Policy, Planning and Budget; OMH Associate Director for Planning and Policy Coordination, tribal leadership, tribal behavioral health staff and tribal law enforcement	The purpose of this meeting was to discuss the HHS Indian Country Methamphetamine Initiative and the Winnebago Nation's role as a prevention site.
22-Aug-06	Meeting with the Association of American Indian Physicians (AAIP)	SAMHSA's Tribal Specialist, Office of Policy, Planning and Budget; OMH Associate Director for Planning and Policy Coordination, and AAIP Executive Director	The purpose of this meeting was to discuss the HHS Indian Country Methamphetamine Initiative and the coordination role that AAIP will play in this initiative, working with other tribal partner organizations and tribal prevention, intervention; treatment and recovery sites.

Date	Event	In Attendance	Summary
30-Aug-06	Meeting with the Navajo Nation in Window Rock, Arizona	SAMHSA's Tribal Specialist, Office of Policy, Planning and Budget; OMH Associate Director for Planning and Policy Coordination, Director, Navajo Division of Health, Department Manager, Navajo Division of Behavioral Health Services and Executive Director, Navajo. Division of Public Safety.	The purpose of this meeting was to discuss the HHS Indian Country Methamphetamine Initiative and the Navajo Nation's role as an intervention and treatment site.
22-Sep-06	Meeting with NCAI and NICWA at SAMHSA Offices	SAMHSA's Acting Deputy Administrator and Senior Advisor for Tribal Affairs met with NCAI Research Director and Legislative Associate and NICWA Executive Director	Issues included suicide prevention strategies and plans for SAMHSA's 2007 Tribal Co-Occurring Disorders Policy Academy

REGIONAL TRIBAL DELEGATION MEETINGS

Date	Event	In Attendance	Summary
Region II			
6/1/2006	Meeting with Seneca Nation	Office of Women's Health, OPHS, Seneca Nation	Funded a mini-grant to buy supplies for summer youth camp for Native American girls.
8/1/2006	Meeting with St. Regis Mohawk	Office of Family Planning, OPHS, St. Regis Mohawk	Provided a grant for a prenatal publication, $2500.
8/1/2006	Telephone conversation	Regional Director, NYS Department of Health and St. Regis Mohawk Tribe	RD Konopko responded to an inquiry from the NYS Department of Health regarding pharmacy reimbursement questions related to the St. Regis Mohawk's plan to establish a pharmacy that would bill Medicaid. The RD referred the Department to the appropriate representatives within the IHS.
9/1/2006	Telephone conversations with Oneida	Office of Minority Health, OPHS, Oneida	Coordinated visit with Oneida, has been postponed twice. Rescheduled for Spring.
9/1/2006	Communicate with Tribe and CMS	CMS and St. Regis Mohawk	Provided St. Regis Mohawk with a contact at CMS that they can speak to about Tribal ID as proof of citizenship.

Date	Event	In Attendance	Summary
On going	Conference calls with St. Regis Mohawk	Office of Minority Health, OPHS, St. Regis Mohawk	Worked regularly on program issues such as diabetes, substance abuse, obesity and SAMSHA.
September 2006 and as needed	Met at NYS Pandemic Flu Summit and held conversations with St. Regis Mohawk	ORD, OPHEP, and OPHS, emergency preparedness representative from St. Regis Mohawk Tribe	Assist with Emergency Preparedness Community Plan, specifically with regard to Pandemic Flu preparation.
9/1/2006	Email distribution of SAMHSA Tribal Report	ORD and Region II tribes	The ORD provided all the tribal leaders in Region II with copies of the recently released response by SAMHSA of issues raised during the Tribal Consultation held in Washington last March.
10/1/2006	Seneca Nation	Office of Minority Health, OPHS, Seneca Nation	OMH provided funds for the Seneca nation to come to a Health Prevention Summit on October 2006
3/1/2006	Visit to the Native American Community Services of Erie and Niagara Counties, NY	OPHS, National HIV/AIDS Mobilization Campaign Coordinator and Native American Leaders	Native American Community Services of Erie and Niagara Counties, Inc. hosted a visit with OPHS. They also received a grant to enhance their HIV/AIDS services.
Region IV			
5/1/2006	Meeting with Choctaw Chief Phillip Martin	Region IV Regional Director Chris Downing, IGA Specialist Deric Gilliard	The meeting offered an opportunity to meet with Choctaw Chief Phillip Martin and his staff at the Choctaw reservation in Choctaw, MS. Choctaw Health Director Jimmy Wallace provided the RD with a tour of the Head Start Center, the headquarters and the hospital, as well as the proposed hospital, which could open as early at 2010. The hospital serves Choctaw citizens in eight different communities within the region.
Region IV CMS			
7/27/2006	Conference call with Eastern Band of Cherokee Indians (EBCI), NC	Deputy Health Officer, Tribal Attorney, Medical Compliance officer, Psychologist, Operations Director, RO financial analyst for NC, NAC.	Conference call requested by the Tribal Deputy Health Officer. The issue is that the Cherokee are unable to access the Unity Regional Youth Treatment Center for referrals. The RO financial analyst explained Unity's policy (furnished a follow-up e-mail).

Date	Event	In Attendance	Summary
7/27/2006	Conference call with Poarch Band of Creek Indians (PBCI), AL	CO - Senior Advisor, Senior Policy Advisor, AI/AN Programs, Waiver staff. Tribal - Family Services Dept. (FSD) Exec. Director, FSD Elder Day Care Coordinator, Tribal Administrator. RO - Waiver Team Leader, Eligibility Team Leader, NAC	The CO Senior Advisor scheduled this call at the request of the Elder Day Care Coordinator. The PBCI Family Services Department is requesting to become a Medicaid provider for Targeted Case Management for Adult Protective Services, and Technology Assist
Region V			
9/1/2006	Region V T/TA Consultation meeting	Region V TANF staff	Region V staff held a consultation meeting and provided T/TA to Tribal TANF and NEW grantees through Regional Office-sponsored T/TA Conference for Tribal TANF grantees, September 2006.
7/1/2006	IV-D Tribal Consultation meeting	Region V Child Support staff	Region V Child Support staff held a consultation meeting to provide technical assistance to three Tribal IV-D applicants as they pursue completion of the Tribal IV-D Start-up applications.
8/1/2006	Technical Assistance Meeting	Region V Child Support staff	Region V Staff held a consultation meeting to provide technical assistance to Tribes in a variety of areas, such as: audit issues, reporting requirements, special initiatives, child support questions, new director training, and various policy matters.
9/17/2006	Review of Greater Minneapolis Council of Churches' Healthy Native Fathers Project. The project serves urban tribal members	Joseph Smyth from ACF/Regional Office, Project Director Carol Ladd, Project Coordinators Richard Antell and Robert Klanderud	Meeting to discuss: program administrative issues, services provided, service levels, future plans, partnerships, program evaluation, required technical assistance and development of domestic violence protocols.
8/1/2006	Call with Pokagon Tribe	Region V ACF staff	Consultation was held to provide information to a Pokagon Tribe inquiring about the possible initiation of a Tribal TANF program.
Region VI			
12/15/2005	Meeting with Navajo Nation	CMS Regional and Central Office staff; Navajo Nation representatives	CMS met with Navajo Nation of discuss eligibility streamlining and simplification with 3 Medicaid agencies that serve the Navajo Nation. The Navajos are exploring eligibility simplification with a common electronic Medicaid application that could be used in

Date	Event	In Attendance	Summary
			the three states.
4/3/2006	Teleconferences with Choctaw Nation	Mickey Peercy (Choctaw), Ashlea Quinonez (HHS)	Hospice provider issue. HHS Office for Civil Rights determined that provider had been approved for Medicare participation
5/16/2006	ACF Tribal Program Briefing with Choctaw Nation - Durant, OK	Choctaw Chief Gregory Pyle and senior tribal officials; ACF staff	ACF staff presented an overview of ACF tribal programs and services with a strong focus on the Tribal Child Support Program. Additional information on leveraging of resources, upcoming ACF funding opportunities and technical assistance events was delivered.
6/1/2006	Meeting with Jicarilla Apache Judiciary - Dulce, NM	Chief Judge Shawn Perry, Judge Roman Duran, Judge Muniz and ACF Tribal Child Support staff	Staff delivered an overview of ACF programs and services available to tribal governments with a strong focus on Tribal Child Support Enforcement with members of the Jicarilla Apache Nation Judiciary to solicit an informed decision regarding the feasibility of administering a direct-funded tribal program.
Region VII			
Many throughout the year	Kickapoo Tribe in Kansas, Ponca Tribe of Nebraska, Omaha Tribe of Nebraska, Prairie Band Potawatomi Nation, Santee Sioux Nation, and Winnebago Tribe of Nebraska	RD and Tribal Policy Council members as appropriate	As part of an ongoing effort to include Tribal Nations in communications on grant opportunities, news items of interest, and any updates or general information, the RD sends numerous communications to the Tribal Chairs
Region X			
11/3/2005	Rural Alaska CAP	Region 10 RD	Met with David Hardenbergh, Executive Director, and Debbie Baldwin, Child Development Director. They discussed the Deputy Secretary's August 05 visit to Savoonga and Dr. Horn's commitments regarding upgrades to the Savoonga Head Start facility.
2/23/2006	Access to Health Care Coalition	Region 10 RD & IGA Specialist	Met with Board of Clallam County Commissioner Howard Doherty, Clallam County Health & Human Services, Lower Elwha Klallam Tribe and others to discuss health and human services issues in the County.

Date	Event	In Attendance	Summary
June 19-20, 2006	Lower Elwha Klallam Tribe	Region 10 RD & IGA Specialist	Met with Cecille Greenway, health and social services director for the tribe. She provided a briefing and tour of the new tribal clinic and discussed several tribal TANF issues.
August 8-12, 2006	Deputy Secretary Azar's Trip to AK	Region 10 RD, Deputy Secretary, IHS Area Director, HHS CO Representatives (CMS, IGA, HIS, ASL, ACF, SAMHSA, ICNAA), AK State Officials, AK Congressional Representatives.	RD participated in the Deputy Secretary's Trip. Site visits included: Anchorage (Alaska Psychiatric Institute, North Star Hospital, State of AK Dept of Environmental Conservation and Public Health Labs, St Paul Island (Health Center and Tribal Building), Sitka (Center for Community, Sitka Pioneers' Home, Sitka Community Hospital, and Ravens Way Youth Residential Treatment Center), Ketchikan (Ketchikan Indian Community Clinic, Gateway Center for Human Services, Ketchikan General Hospital), and Metlakatla. They participated in the Bi-Annual meeting of the Alaska Tribal Leadership, Health Directors and
			State Partners, including the Behavioral Health Roundtable. They met with the Chugachmiut, Inc, Aleutian/Pribilof Islands Association, Aleut Community of St Paul, Central Bering Sea Fisherman's Association, Southeast Alaska Regional Health Consortium, Alaska Family Practice Residency Program, and Alaska Physician Shortage Task Force. They also held a listening session with local commercial healthcare providers in Sitka.
September - October 2006	Makah Tribe, Neah Bay, WA	Region 10 RD & EO	Participated in conference calls regarding the water shortage and implementation of temporary measures to alleviate the problem.

WORKGROUPS AND TASK FORCES

When new or revised national policies affect an Indian Tribe or Tribes, HHS can establish workgroups or task forces to develop recommendations on technical, legal or policy issues. In 2006, HHS convened workgroups to address issues, such as Medicare, barriers to access, legislation, long-term care, health disparities, budget formulation and consultation policies.

DIVISION WORKGROUPS AND TASK FORCES

Date	Event	In Attendance	Summary
Administration for Children and Families (ACF)			
First Tuesday of the Month	ACF Native American Affairs Work Group - ANA facilitates meetings	Management representatives from ACF Central Program Offices and Region X RA/designee. ANA is work group lead.	Discussions to improve services and communications with Tribes and Native Communities.
Dec., 05	ACF Tribal Consultation & National Native Affairs Conference	ACF Senior Leadership; Tribal Leadership; and Tribal and Native Program Representatives.	Consultation Executive Summary is posted on ANA website. Technical assistance workshops on access to ACF funding.
ACF/Administration for Native Americans (ANA)			
Bi-annual	Bi-annual meetings; HHS Tribal Budget Consultation	HHS Council and Liaisons.	Reports and updates on meeting the needs of Tribes and Native communities.
ACF/Child Care Bureau (CCB)			
Periodic	102-477 Work Group	Senior Management from ACF; Department of Interior; Department of Labor; Tribal Employment and Training Directors.	The 102-477 Work Group was established by Tribes to play a major role in the implementation and oversight of Public Law 102-477, the Indian Employment, Training, and Related Services Demonstration Act of 1992. This Work Group works with Federal agency partners to monitor participation in Public Law 102-477 and promote coordination.
ACF/Office of Child Support Enforcement (OCSE)			
Nov., 05	Tribal/State Cooperation Work Group meeting	OCSE, Tribal IV-D Grantees.	Issues discussed included a distribution draft document, inter-jurisdictional enforcement issues, case transfer, referral and closure, impact of mandatory medical support by States on Tribal members.
ACF/Office of Family Assistance (OFA)			
Throughout the Year	Participated in the Public Law 102-477 Federal Partners and Tribal Work Group meetings	Federal partner agencies, i.e. Department of the Interior, Department of Labor, HHS Children's Bureau; and Tribes participating in 102-477 demonstration projects.	4/11/2006 - Met and consulted with Tribes and other Federal partners participating in the Public Law 102-477 demonstration. 8/7/2006 - Met and consulted with Tribes and other Federal partners participating in the Public Law 102-477 demonstration. 5/16/2006 - Conference call and consultation with Tribes and other Federal partners participating in the Public Law 102-477 demonstration. 10/01/2005 thru

Date	Event	In Attendance	Summary
			9/30/2006 - Various calls with Tribes providing technical assistance relating to administration of TANF programs in 102-477 projects.

Date	Event	In Attendance	Summary
Administration on Aging (AoA)			
Ongoing	Long-term Care in Indian Country	Yvonne Jackson and Meg Graves, AoA, Bruce Finke, HIS, Dorothy Dupree, Anita Yuskauskas, and Priya Helweg, CMS, Norma Meriman, Cherokee	This workgroup formed the planning committee for the second annual conference on Long Term Care in Indian Country which was held in September in Tulsa, Oklahoma. The conference was designed to provide a forum where
		Nation, Kathy Correa, Laguna Pueblo, Kay Branch, Alaska Native Tribal Health Consortium, Steve Wilson, Muskogee (Creek) Nation, Connie Bremner, Blackfeet Nation, and others.	tribes and AI/AN organizations engaged in the development of long term care services can: 1) learn from each other about promising practices in sustainable programs of long term care; 2) learn about resources available to help in the development of long-term care services; and 3) learn from experts in the field about specific technical issues.

Date	Event	In Attendance	Summary
Centers for Disease Control and Prevention (CDC)			
December 2005 through present	CDC and National Cancer Partners AI/AN Advisory Workgroup	Newly established workgroup was formed based on tribal recommendations provided at the *Advancing Parity in Comprehensive Cancer Control With AI/AN Populations: Comprehensive Cancer Control Leadership Institute.* CDC and all national cancer partners, AI/AN professionals and tribal leaders involved in cancer prevention across Indian country.	Workgroup meets at least on a quarterly basis or as frequently as need dictates to advise national partners about Comprehensive Cancer Control (CCC) needs of AI/ANs. Workgroup has played as integral role in planning the Annual Tribal and CCC Leadership Institutes and assisting and assuring tribes have greater accessed to these resources and programs. They also have been working with DCPC to communicate to states the role they play in assuring CDC resources get to AI/ANs.

Date	Event	In Attendance	Summary
May of 2006 through present	CDC Tribal Pandemic Influenza Preparedness Work Group	An ad hoc, internal CDC work group established by OMHD/OSI/OD to facilitate internal communications and information sharing about pandemic influenza preparedness in AI/AN communities. Meet by conference call monthly to ensure improved collaboration and coordination of activities.	Specific activities have included the following: providing subject matter expertise to the CDC Pandemic Influenza Coordinating Group and its functional area teams, developing an inventory of communication channels with tribes, tribal organizations, and tribal stakeholders to assist National Center for Health Marketing and the Office of Enterprise in making pandemic flu preparedness information available to AI/AN communities, helping ensure that information and guidance specific to avian influenza is available to AI/AN communities - particularly where subsistence hunting of water fowl is common practice, assisting in coordinating tribal pandemic flu preparedness activities with the IHS, interfacing with tribally-focused HHS committees (e.g., Secretary's Intradepartmental Council on Native American Affairs- ICNAA; HHS Tribal Health Research Advisory Council), and monitoring pandemic influenza preparedness activities at CDC to ensure compliance with CDC and HHS Tribal Consultation Policies.
January of 2006 through present	CDC Public Health Law Workgroup	CDC staff and Valerie Davidson (JD, & Intergovernmental Affairs/ ANTHC), Joe Finkbonner, (MPH/Executive Director, of the NW Portland Area Indian Health Board), Hilary Frierson, JD (Attorney with OGC/HHS, IHS Branch), Tim Gilbert, MPH (Senior Director, Division of Comm. Health, ANTHC), Mechelle Johnson, JD (Attorney with OGC/HHS, IHS Branch), Myra Munson JD, MSW (former state of AK Health Commissioner, Turning Point Project	Workgroup is in the process of planning a Tribal Forum on Legal Foundations for Public Health Practice in Indian country for May 17 - 18, 2007 in Anchorage, Alaska. Forum will be sponsored by the Alaska Native Tribal Health Consortium, South Central Foundation, and CDC. It is intended that the Forum will be a working meeting of tribal, state, and federal public health professionals and consultant legal experts to discuss the current status of public health legal preparedness in Indian country, to identify gaps in public health legal foundations, and to develop an initial plan of action to address these gaps.

Date	Event	In Attendance	Summary
		consultant; currently in private legal practice	
		in Juneau), JT Petherick JD, MPH (former Exec Dir National Indian Health Board, currently Health Legislative Officer, Cherokee Nation, OK), Teresa Wall, BSN, MPH (former Exec Director, Dept of Public Health, Gila River Indian Community; Turning Point project consultant.	
August 2006 through present	The CDC Division of Heart Disease and Stroke Prevention recently formed an advisory workgroup to gain an understanding of the barriers that impact AI/AN populations understanding of MI signs and the delays in treatment following an MI.	Workgroup meets monthly and consists of tribal persons, one WISEWOMAN project coordinator (Alaska), two Heart Disease and Stroke Program Coordinators (Montana, Alaska), and CVD HP2010 Partners, including American Heart Association, IHS, and National Heart Lung and Blood Institute.	Workgroup is currently working on formulating questions to be used in interviews and focus groups to develop culturally tailored messages that customize the "Act in Time" national campaign; identify methods and style of delivery for the messages; identify innovate intervention strategies; and pilot the messages with MI patients and their families in the Native American Cardiology Program.

Date	Event	In Attendance	Summary
Centers for Medicare and Medicaid Services (CMS)			
2/23/2024	CMS Tribal Technical Advisory Group	Tribal Technical Advisory Group Members; key staff from CMS, IHS, DHHS, OGC, etc…; interested public	Issues discussed included: • Medicaid • Deficit Reduction Act (DRA) • Reduction in Payments for Drugs under DRA • Citizenship Documentation under DRA • Medicare-like Rates Regulations • Medicare Part D • CMS LTC Vision • SCHIP funding • Data • Outreach and Education • MAM
6/8-9/2006	CMS Tribal Technical Advisory Group	Tribal Technical Advisory Group Members; key staff from CMS, IHS, DHHS, OGC, etc…; interested public	see above

Date	Event	In Attendance	Summary
11/14-15/2006	CMS Tribal Technical Advisory Group	Tribal Technical Advisory Group Members; key staff from CMS, IHS, DHHS, OGC, etc…; interested public	see above
Monthly	Teleconference calls	TTAG & invited staff	Key policy topics and routine business
Periodically	TTAG Subcommittee Meetings	TTAG, CMS, IHS staff Subcommittee members	Subcommittees: • Budget and Strategic Planning • CMS Day Planning • Consultation Policy • Cross State Boarders • Data • Equitable Relief • MAM • Medicare-like rates • Outreach and Education • Part D Implementation • Policy • Small Team

Date	Event	In Attendance	Summary
Health Resources and Services Administration (HRSA)			
No date given	HRSA/BPHC and IHS	HRSA/BPHC staff: Jean Hochron, Pocahontas Wilkinson, IHS staff: Phyllis Wolfe, Danielle Steward	Assist in development of strategies to obtain 330 funding to develop AI/NA health centers. Met in Wash. D.C. with several Tribes that were interested applying for funds.

Date	Event	In Attendance	Summary
Indian Health Service (IHS)			
3/29-30/2006 10/18-19/2006	Information Systems Advisory Committee	6 Tribal Leaders and representatives and 9 IHS staff from throughout IHS system.	The Committee met twice during 2006 and discussed issues such as the electronic health record, capital planning and investment control, security requirements, 5-Year information technology strategic plan, enterprise architecture, information technology enterprise solutions, etc.
Qtrly	Direct Service Tribes Advisory Committee (DSTAC) Meeting	IHS Director and other support staff from IHS HQ	DSTAC met to discuss current status of health concerns and issues of Tribal Leadership for the Direct Service Tribes (DST). Plan for the national consultation meeting for all DST to provide information and education with regard to those factors affecting their health care services.

Date	Event	In Attendance	Summary
October 1, 2005 - September 30, 2006	National Indian Health Board (NIHB)	The NIHB Board of Directors, comprised of Tribal Leaders and representatives, met with the Director, IHS, and other staff on a quarterly basis	The NIHB is a source of ongoing advice and consultation to the IHS on a variety of matters affecting the IHS budget, national Indian health delivery issues, collaborations with State governments and other Federal agencies, etc.
October 1, 2005 - September 30, 2006	IHS/Tribal Contract Support Cost (CSC) Workgroup	The CSC Workgroup is open to all Tribal leaders and representatives and IHS and Federal staff with an involvement or interest in the administration of CSC within IHS.	The Workgroup met once during fiscal year 2006 to examine potential changes to current policy concerning the administration of CSC and how these costs are allocated to tribes and tribal organizations.

Date	Event	In Attendance	Summary
National Institutes of Health (NIH)			
NIH/National Heart, Lung, and Blood Institute (NHLBI)			
Item 1 11/29/05 02/23/06 04/11/06 06/08/06 08/30/06	NHLBI's Honoring the Gift of Heart Health (HGHH) Project Conference Calls on NHLBI-IHS Cardiovascular Health (CVH) Partnership to Implement Heart Health Training in AI/AN communities	IHS Native American Cardiology Program Drs. James Galloway and Mark Veazie; Dr. Rob Fulwood and Rachael Tracy, NHLBI	Discussion of new partnership and possible project activities with other components of IHS that are involved in delivery of health information to AI/AN populations. This activity focuses on cardiovascular health disparities in AI/AN communities.
Item 2 2/5-9/06	NHLBI-IHS Regional CVH Training Workshop	25 Tribal community trainees from the Oklahoma IHS Service Area; Rachael Tracy and Janet De Jesus, NHLBI	Trained tribal community representatives, health educators, community health representatives, dieticians on the Honoring the Gift of Heart Health Training.
NIH/National Institute of Child Health and Human Development (NICHD)			
Monthly Conference call	The NICHD Healthy Native Babies Work Group	The Work Group included representatives from Aberdeen, Alaska, Bemidji, Billings and Portland, as well as NICHD/NIH staff and contract support staff.	The Work Group formed to plan outreach activities designed to help reduce the risks of Sudden Infant Death Syndrome in American Indian and Alaska Native communities. The Work Group reviewed the design and content of a work book and an interactive CD that is being used by community health outreach representatives.

Date	Event	In Attendance	Summary
Substance Abuse and Mental Health Services Administration (SAMHSA)			

Date	Event	In Attendance	Summary
July 17-19, 2006	SAMHSA Tribal Consultation Policy Revision Workgroup (meeting at United South and Eastern Tribes' office in Nashville, TN)	Anselm Roanhorse of Navajo Nation, Division of Health; Trudy Anderson formerly of the Alaska Native Health Board; Verne Boerner of Northwest Portland Area Indian Health Board; Tom John of Chickasaw Nation; and See Sabbattus of United South and Eastern Tribes; Eugenia Tyner Dawson, formerly of HHS-Office of Minority Health; Valerie Jordan and Beverly Watts-Davis of SAMHSA.	Technical workgroup consisting of tribal leaders, tribal representatives and key SAMHS and HHS staff members made revisions to existing Draft SAMHSA Tribal Consultation Policy. A Dear Tribal Leader letter transmitted document and requested comments during a 90-day review period, ending December 31, 2006. SAMHSA expects to sign the policy in February 2007.
July 29 – August 2, 2006	SAMHSA Tribal Grants Access Group	Leonard Baker, Mandan, Hidatsa and Arikara Nation; Jerry Folsom, Choctaw Nation of Oklahoma; Linda Holt, Chairwoman, Northwest Portland Area Indian Health Board and Councilwoman, Suquamish Tribe; and Bryan Myles of Wampanoag Tribe of Gay Head Aquinnah	Technical workgroup of tribal leaders and tribal representatives review agency Requests for Applications (RFAs) from a tribal perspective, providing comments on suggested language changes, in conjunction with the HHS Grants Access/Barriers Study.
[IGA completes]	Workgroup on "Grants Access/Barriers Study"	[IGA completes]	SAMHSA contributed suggestions to ASPE during the study design phase, information collection phase and on the draft final report.
Monthly	White House Indian Affairs Executive Workgroup	Federal Agency representatives	SAMHSA is a member.
Monthly	ONDCP Law Enforcement Task Force	Federal Agency representatives	SAMHSA is a member.
Monthly	IHS Methamphetamine Workgroup	IHS, SAMHSA, DOI, USSS, DOJ, ONDCP, NCAI, Matrix, Inc., One Sky Center, and White Bison	Monthly Conference call to coordinate activities and share information on methamphetamine efforts. IHS has the lead for this workgroup.
Periodic	HIV/AIDS Collaborative Region Training and Workgroup	SAMHSA and IHS	Workgroup is planning five HI V/AIDS Collaborative Regional Trainings for Native American clinicians and traditional service providers that will be held in FY 2007. IHS has the lead for this workgroup.

REGIONAL WORKGROUPS AND TASK FORCES

Date	Event	In Attendance	Summary
Region II			
Quarterly	Centers for Medicare & Medicaid Services Tribal meetings	CMS, three Tribal Leaders	The group meets four times a year via telephone to discuss issues that the Tribes may have.
As needed	Healthy People 2010 planning committee	OPHS, three Tribal Leaders	The planning committee met several times via phone to discuss and organize the Healthy People 2010 conference.
12/01/2006	Body Works Obesity prevention Toolkit Training	OPHS, Community-based organizations, and two Tribes	Seneca Nation and St Regis Mohawk participated in the training on obesity prevention for adolescent girls.
Region VI			
1/30/2006	Region VI Intra-Agency Tribal Issues Team	HHS ORD, CMS, ACF, RHA, AoA, IHS; Navajo Nation: Oklahoma City Inter-Tribal Health Board, USET	Team met to discuss plans for 2006 Regional Consultation Session in Albuquerque, NM
3/2/2006	Region VI Intra-Agency Tribal Issues Team Agenda Planning Committee	HHS ORD, CMS, ACF, RHA, AoA, IHS; Navajo Nation: Oklahoma City Inter-Tribal Health Board, USET	Committee met to plan agenda for Regional Consultation Session
12/6/2006	Region VI Intra-Agency Tribal Issues Team Agenda Planning Committee	HHS ORD, CMS, ACF, RHA, AoA, IHS; Navajo Nation: Oklahoma City Inter-Tribal Health Board, USET	Team met to discuss plans for 2007 Regional Consultation Session in Oklahoma
Throughout 2006	CMS Regional Office Tribal Workgroup	CMS RO Division Representatives	Members meet on an "as needed" basis to discuss and work on concerns and issues of Native American tribes in the Dallas region.
Region VII			
January-March 2006	Region 7 Tribal Planning Workgroup	ORD Staff, Emergency Preparedness, ACF, AoA, ATSDR, CDC, CMS, FDA, HRSA, HIS, OCR, OPHS, and SAMHSA	To plan the Region 7 Tribal Consultation
The 4th Wednesdays of each month	Region 7 Tribal Meth Workgroup Conference Call	OPHS, ORD, EPA, ACF, CMS, Tribal Chair Roger Trudell	The primary goal of this newly formed group was to learn what the issues are surrounding the meth problem in Indian Country and secondly decide the next course of action for the Tribes in Region 7.OPHS involved the Nebraska Dept of Health and proposed conducting a Meth Training co-sponsoring with the Nebraska Dept of Health

OTHER DIVISION-SPECIFIC CONSULTATION EFFORTS

Date	Event	In Attendance	Summary
Administration for Children and Families (ACF)			
ACF/Administration for Native Americans (ANA)			
3/15/2006	Native Wellness Institute - Reno, NV	ANA Commissioner Stamps; Chairman Gordon James; Pam James.	Discussion of ANA Grant, community wellness and youth development.
3/29/2006	National Indian Women's Health Resource Center	ANA Commissioner Stamps; Pamela Iron, Executive Director; NIWHRC staff.	Discussed two ANA Grants and visited a local middle school where healthy relationship curriculum was being tested.
4/24/2006	Sacred Circle - Rapid City, SD	ANA Commissioner Stamps; Executive Director, Karen Artichoker.	Discussion about domestic violence in Native communities and possible partnerships between Sacred Circle and ANA Healthy Marriage grantees.
4/24/2006	The Lakota Fund - Kyle, SD	ANA Commissioner Stamps; Executive Director, Dowell Caselli-Smith.	Discussion of ANA grant "Oyate Woableza Otipi - A Place of Understanding of the People" successes and challenges.
4/25/2006	Alliance of Tribal Tourism Advocates - Rapid City, SD	ANA Commissioner Stamps; ATTA Chairman Robert Cournoyer; and other ATTA Officers and Directors.	Overview of ATTA history and current programs; review of current ANA Project grant and discussion of ATTA collaborations, recurring revenue, and plans for the Powwow Garden/Indian Arts Market.
4/26/2006	Minneapolis Indian Health Center - Minneapolis, MN	ANA Commissioner Stamps; Frances Fairbanks, Executive Director; other Center staff.	Discussion of ANA grant project "Indian Child Welfare Act Compliance Project;" demonstration of database; site visit of the Minneapolis Indian Health Center during community health fair.
4/27/2006	Red Lake Reservation - Red Lake, MN	ANA Commissioner Stamps; Red Lake Community members.	Site visit of the Red Lake facilities - Redby, Ponemah, and Little Rock Community Centers, and the Red Lake and Ponemah Pow-wow Arbors that benefited from ANA Grant funding.

Date	Event	In Attendance	Summary
6/6/2006	Great Lakes Indian Fish and Wildlife Commission (GLIFWC) - Ashland, WI	ANA Commissioner Stamps; Jim Saint Arnold; representatives of 3 ANA site projects, Red Cliff Vice Chair.	Discussed the "Anishinaabe Language Natural Resource Project" and demonstration of electronic language dictionary; discussion of the "Treaty Fisheries Intertribal Community Food Program"; site visit to local businesses that benefited from ANA funding on the Red Cliff Reservation; attended a fish boil that promotes healthy living and economic generation for fishermen; discussed Great Lakes Annex and Regional Collaboration Program with project staff.
6/6/2006	Bad River Band of Lake Superior Tribe of Chippewa - Ashland, WI	ANA Commissioner Stamps; Jackie Rose, Tom Doolittle.	Discussed Fish Hatchery Improvement Project success and challenges; Toured fish ponds and hatchery center.
6/7/2006	Lac Courte Oreilles Band of Lake Superior Chippewa - Hayward, WI	ANA Commissioner Stamps; representatives of two ANA site projects.	Met with Indian Fish & Wildlife Commission; Site visits to ANA funded projects.
8/22/2006	Sealaska Heritage Institute - Juneau, Alaska	ANA Commissioner Stamps; President, Dr. Rosita Worl; Chief of Operations, Sandy Samaniego; Staff of ANA projects.	Overview presentation of the Institute and presentation of reports on ANA projects; Discussion of language immersion and economic development activities.
8/28/2006	Nanakuli Housing Corporation - Honolulu, HI	ANA Commissioner Stamps; Kapiolani Barber, Executive Director; and other officers and managers.	Discussion of objectives and deliverables of the ANA Project "Hano Hou! (Take Something Old-Make It New." Toured renovated training classrooms and renovated base yard appliance warehouse; Met with community partners.
8/28/2006	Office of Hawaiian Affairs - Honolulu, HI	ANA Commissioner Stamps; Clyde Namu'o, Administrator of OHA; Board of Trustees, OHA.	Discussion of status of Native Hawaiian Revolving Loan Fund.
8/29/2006	Hana Community Health Center - Hana, HI	ANA Commissioner Stamps; Cheryl Vasconcellos, Executive Director; officers and Board members.	Site visit of HCHC and Hana Fresh Farm. These are part of ANA project: Sustainable Farm and Workforce Development Program; Discussion of economic generation activities and recurring revenue.
8/30/2006	Healani Canoe Club Honolulu, HI	ANA Commissioner Stamps; Rose Lum, Project Coordinator; Paulani Paiaina, Vice President.	Toured restoration site and discussion of ANA grant project including language and cultural preservation and youth development.

Date	Event	In Attendance	Summary
8/30/2006	State Council of Hawaiian Homestead Associations - Honolulu, HI	ANA Commissioner Stamps; Paul Richards, Executive Director; Jade Danner, General Manager, HI Homestead Technology; Community leaders; Presidents of Community Associations.	Toured digitization center and community center; Discussed grant project with staff and participants.
ACF/Child Care Bureau (CCB)			
3/6/2006	Consultation Letter	Tribal Child Care Grantees.	The Child Care Bureau mailed a letter to all Tribal Child Care Administrators asking for their input on appropriate technical assistance mechanisms. This input was used to craft a new technical assistance contract for Tribes.
ACF/Children's Bureau (CB)			
12/6/2005	Dear Tribal Leader Letter	N/A	Children's Bureau sent letters to Tribal Chairs and Tribal Social Service Directors requesting consultation on the Tribal funding mechanism in the title IV-B, subpart 2 legislation.
3/17/2006	Children's Bureau instituted a Tribal listserv	All Tribes with email addresses were added to the list.	This serves as a communication vehicle for Tribal Directors of Social Services.
11/16/2005	1st Conference Call with Tribes across the Nation	ACF Regional Offices, State Tribal Liaisons, one Tribal Director of Social Services.	The Associate Commissioner of the Children's Bureau is holding regular calls with Tribal Directors of Social Services to inform them of new developments in law, policy or other issues specific to Tribes and to be available to hear questions, concerns, etc.
3/28/2006	2nd Conference Call with Tribes across the Nation	ACF Regional Offices, State Tribal Liaisons, Tribal Directors of Social Services (38 lines used).	This call was used as a networking call between Tribes as multiple questions were asked and answered by each other. One result of the call was a greater sharing of State/Tribal Title IV-E agreements.
11/21/2006	3rd Conference Call with Tribes across the Nation	ACF Regional Offices, State Tribal Liaisons, 15 or more Tribal Directors of Social Services.	These calls are becoming more popular with Tribes. This call focused on the new Promoting Safe and Stable Families (PSSF) legislation and its effect on Tribes.
ACF/Family and Youth Services Bureau (FYSB)			
6/1/2006	Mentoring Children of Prisoners (MCP) Meeting in Washington, DC	MCP Grantees and FYSB Staff.	Met individually and collectively with Tribal grantees regarding strategies for developing effective and responsive MCP programs in Indian communities.

Date	Event	In Attendance	Summary
Nov., 06	MCP Meeting in Washington, DC	MCP Grantees and FYSB Staff.	Met individually and collectively with Tribal grantees regarding strategies for developing effective and responsive MCP programs in Indian communities.
Ongoing	Ad hoc informal consultation	Staff, Program Directors, Associate Commissioner.	Associate Commissioner, Staff, Program Directors use opportunities at National Conferences, Regional meetings, phone conversations, etc. to gather input from Tribes and Native issues on all FYSB programs.
ACF/Office of Child Support Enforcement (OCSE)			
Dec., 05; May, 06; Aug., 06	1) Inter-Tribal Council of Arizona; 2) ACF Region X Tribal/State Summit; 3) NTCSA Annual Conference, WI; 4) ACF Region X IV-D Directors Meeting	1) OCSE and Arizona Tribes; 2) OCSE and ACF Region X Tribes; 3) OCSE and National Tribes; and 4) OCSE and ACF Region X IV-D Directors.	Notices of meeting were distributed by Tribes in AZ, ACF Region X and National Tribal Child Support Association.
ACF/Office of Family Assistance (OFA)			
12/7/2005	ACF National Native American Conference	Ray Apodaca - OFA.	Conducted a training session "Temporary Assistance for Needy Families (TANF) 101."
12/8/2005	ACF National Native American Conference	Ray Apodaca - OFA and Oscar Tanner, Office of Administration, Division of Grants Policy.	Conducted two breakout sessions on "Use of Tribal TANF Funds and Financial Requirements - Part A" and "Use of Tribal TANF Funds and Financial Requirements - Part B."
12/9/2005	ACF National Native American Conference	Ray Apodaca - OFA.	Assisted ACF financial management staff in conducting a breakout session, "Essentials of Successful Grants Management Accountability, Outcomes and Quality Assurance."
12/6-9/2005	ACF National Native American Conference	Ray Apodaca - OFA.	Had meetings with and provided technical assistance to 13 current Tribal TANF grantees and 9 potential TANF grantees.
12/6/2005	ACF National Native American Conference	Ray Apodaca - OFA.	Met with 5 contractors/service providers on issues relating to Tribal TANF.

Date	Event	In Attendance	Summary
12/1/2005	Health and Human Services Intergovernmental Affairs (HHS IGA) - American Public Human Services Association (APHSA) - National Congress of American Indians (NCAI) Meeting	Federal: Ray Apodaca and Robert Shelbourne - OFA; Others: HHS IGA, APHSA, and NCAI staff and members.	Participated via conference call in a five hour HHS IGA - APHSA - NCAI sponsored meeting in Denver, Colorado. The participants included state and tribal human service agency personnel. The meeting focused on intergovernmental and cross program coordination. The participants raised questions and issues about coordination, discussed challenges, exchanged program policy information, and collaborated on the formulation of solutions.
3/10/2006	HHS Division Budget Consultation		
3/22/2006	Meeting with the Child Care and Development Fund - Tribal Work Group	Federal: Robert Shelbourne, and Ray Apodaca - OFA, Ginny Gorman, CCB, Ellie Wagner, NCCI Center CCB and ACF Region 6,8, and 10 staff Tribal and others: Joe Francis, Penobscot Indian Nation; Todd Waite, Seneca Nation of Indians; Stan Bienick, eastern Band of Cherokee Indians; Sheila Kimble, Sault Ste. Marie Tribe of Chippewa Indians; Kathy Winers, Wichita & Affiliated Tribes; Francis Big Crow, Oglala Sioux Tribe (via phone); Elizabeth Fortune, North Fork Rancheria; Michelle Steik, Ninilchik traditional Tribe; Adele Guyer, Confederated Tribes of the Umatilla, and Linda Kills Crow and staff from the National Child Care Information Center	Planning for the National Child Care Conference and general discussion of TANF and CCDF partnership.
3/22/2006	Meeting with Board of Directors of the National Indian Child Care Association (NICCA)	Federal: Ray Apodaca, Tonya Taylor, Elaine Richman, Joanne Fradkin, Karen Clairmont - OFA; Tribal: Elase Locust - Cherokee Nation Oklahoma, Dion Wood - Karuk Tribe of California, Connie Guillory - Nez Perce Tribe, Barb Fabre - White Earth Ojibwe Tribe Michael Tinlsey - Inter-Tribal Council of Nevada, Luana	Provided an update on the Deficit Reduction Act of 2005 and TANF reauthorization; responded to questions on reorganization and effect on TANF; provided information on Tribal TANF and Child Care program collaboration possibilities.

Date	Event	In Attendance	Summary
		Genfron - Colville Confederated Tribes, and Tamie Finn - Leech Lake Band of Ojibwe.	
5/16-17/2006	HHS Tribal Budget Consultation		
8/7/2006	National Child Care Conference - Washington, DC	Federal: Bob Shelbourne, Ray Apodaca - OFA; Tribal and other: Various CCDF grantees and State representatives.	Presented a workshop on Tribal TANF and provided direct technical assistance onsite, as requested.

Date	Event	In Attendance	Summary
Agency for Healthcare Research and Quality (AHRQ)			
3/10/2006	1st Annual HHS National Divisional Tribal Budget Consultation	OPDIV/STAFFDIV Principals and Tribal Leaders	Opportunity for tribes to present their budget priorities to HHS.
5/16-17/06	8th Annual HHS Tribal Budget Consultation	OPDIV/STAFFDIV Principals and Tribal Leaders	Opportunity for tribes to present their program priorities to HHS.

Date	Event	In Attendance	Summary
Administration on Aging (AoA)			
Dec. 11-14, 2005	White House Conference on Aging	Kathy Correa, Laguna Pueblo, was appointed to the Advisor Committee, 15 Tribal delegates, including Joe Garcia, President, NCAI were selected by NCAI, and several Tribal delegates were selected by state Senators and Governors.	The delegates recognized several critical priorities that we as a nation must address in the very near future. Many issues were raised, but the following were rated the highest priority: 1) reauthorization of the Older Americans Act; 2) the development of a coordinated and comprehensive strategy for affordable and accessible long term
			care, including caregiver support; and 3) the importance of mobility and transportation options for older Americans.
Feb. 23, 2006 and Jun. 15, 2006	Agency Information Collection Activities: Submission for OMB Review; Comment Request; Extension with Change of the Expiration Date of the Title VI Program Performance Report	N/A	Published in the Federal Register and sent to Title VI grantees.

Date	Event	In Attendance	Summary
Sept. 23, 2006	National Indian Council on Aging (NICOA) Conference	Frank Burns and other AoA staff, 12 NICOA Board members, about 200 NICOA members	Mr. Burns gave the opening keynote speech, followed by a question and answer session. Issues related to the reauthorization of the Older Americans Act and program accountability.

Date	Event	In Attendance	Summary
Centers for Disease Control and Prevention (CDC)			
5/9/2006	DTLL	N/A	The CDC Director sent a DTLL to every Tribal Government, national Tribal Organizations, and Regional Tribal Health Board requesting help in identifying elected tribal leaders to serve on CDC's Tribal Consultation Advisory Committee to be formally established in late 2006 to increase opportunities for tribal input into CDC's decision making processes.
8/24/2006	DTLL	N/A	The Director of the CDC's Division of Cancer Prevention and Control with the assistance of NIHB sent a letter to all tribal leaders requesting their input and consultation regarding the formulation of the new RFA for cancer prevention programs.
Sept.29, 2006	DTLL	NA	The CDC Director sent a letter to all tribal leaders, tribal health boards, and tribal organizations to inform, engage, and consult with them about CDC Goals Management Process. CDC in collaboration with the Partners for Prevention was hosting a series of partner and public engagement meeting to gain input on what people and communities across the country view as most urgent and important along to achieve health impact. This letter also served as an
			invitation to the AI/AN Public Engagement Meeting scheduled as part of the NIHB Consumer's Conference on October 13th. CDC staff listened and recorded tribal leaders ideas and input to assist CDC in formulation of final goals.

Date	Event	In Attendance	Summary
Centers for Medicare and Medicaid Services (CMS)			

Date	Event	In Attendance	Summary
10/10-13/06	22nd Annual NIHB Conference, Denver, CO	CMS Central Office Staff; 3 CMS Regional Office Administrators, CMS Regional staff, Tribal Leaders, health directors, IHS Area Directors/ representatives, State Health Departments, Trailblazer	Conference topics include Medicare Part D, MAM, Medicare-like rates, Medicare & Medicaid 101, Successful Claims Submission, Medicare and Medicaid Issues Affecting Persons w/ Disabilities, Medicaid Reform.
09/16-19/06	National Indian Council on Aging Conference, Tulsa, OK	Central Office and Regional CMS staff	CMS set up an exhibit booth, handed out information, and when asked, discussed the Medicare prescription drug coverage. There were many individuals who stopped by and wanted to learn more about this coverage. The biennial conference was very productive. There were an estimated 1,800-2,000 participants. There were many workshops including Diabetes Prevention, How to talk with your Doctor, and Long Distance Care giving.
'09/16-19/06	2nd Long-term Care Conference, Tulsa	Central Office and Regional CMS staff, IHS, Tribal LTC providers	CMS sponsored this conference and presented CMS LTC Vision
May 8-12, 2006	Self-Governance Tribes Annual Conference	Central Office and Regional CMS staff	CMS Presented on Medicare Part D
March 2 - 3, 2006	Urban Indian Program Training	Regional and CO staff	The purpose of the meeting was to provide training on Medicare Part D to the Urban Program Directors and to review CMS Indian health issues.
June 20 - 22, 2006	Phoenix Area 18th Annual ITU Meeting, Las Vegas, NV	Phoenix Area Senior staff and CEO, Tribal Leaders from AZ, NV, and UT	Provided update to Medicare Part D and addressed leading Medicare and Medicaid issues and concerns of Tribal leaders.
4/7/2006 7/21/2006	Navajo Nation	CMS Region IX Medicaid ARA, CMS Region VI, CMS Region VIII, State Agency Medicaid Directors or their designee for Arizona, New Mexico, Utah	Follow-up meetings were held in Phoenix on 4/7 and Albuquerque on 7/21 with Navajo Nation. CMS and Navajo discussed ways to improve Medicaid enrollment for eligible Navajos. Navajo IT staff gave a presentation on their IT work plan. The goal is to integrate Medicaid
			with other programs into a "one stop" application/enrollment process. Potential impact of DRA provisions on cost sharing alternate benefit package was also discussed. The Tribe expressed interest in improving access to Long Term Care and plans to build a Skilled Nursing Facility at Fort Defiance.

Date	Event	In Attendance	Summary
Health Resources and Services Administration (HRSA)			
October 16-17, 2006	South Dakota Lions Eye Bank	HRSA/Division of Transplantation (DoT) staff and organ donation and social and behavioral consultants	HRSA Grantee Pre-Implementation Workshop—Conducted a Pre-implementation Workshop for all new grantees to provide information regarding new grant projects, strengthening the research, methodology, identifying potential problems, and advising on the conduct of the three year projects to increase organ donation educational efforts. HRSA staff and consultants with expertise in donation and social and behavioral research met with all of the new grantees.
Ongoing throughout 2006	Community development training and technical assistance	Montana Primary Care Association	The State Primary Care Associations (PCAs) have activities mainly centering on community development and providing training and technical assistance to potential applicants that are AI/NA. MPCA continues to work with tribal health entities, the IHS, and Urban Indian clinics on improving access for the Native American population. This special population has some of the highest health disparities in Montana. MPCA has contracted with an Indian Community Health Resource Coordinator who is a member of the Turtle Mountain Chippewa tribe, to serve as a liaison between MPCA and Montanan's five urban and seven tribal health entities. The coordinator assists urban and tribal Indian entities with potential applications for community health center funding and in planning and development of primary medical care practices funded through that mechanism. Urban Indian Clinics and tribal Federally Qualified Health Centers are offered special membership opportunities in MPCA. MPCA provides assistance with cost reports upon request and also has a Medicaid consultant who is available to help these entities with Medicaid issues.

Date	Event	In Attendance	Summary
Ongoing throughout 2006	Community development training and technical assistance	Wyoming Primary Care Association (WPCA)	WPCA has worked diligently with the city, county, and tribal leaders in Fremont County to come to a consensus on the need for a tribal community health center (CHC). The WPCA brought in experts from the Utah Navajo Health Systems to advise the group on the pros and cons of such a system and the leaders in Fremont County have agreed to proceed with it and a formal Corporation has been created – Wind River Development Fund. This corporation will be used to establish the organization that will eventually seek grants and other funds to open a Tribal CHC. However, the WPCA will continue to work with them to leverage State and private financial resources.
Ongoing throughout 2006	Community development training and technical assistance	Community Healthcare Association of Dakotas (CHAD)	Community Healthcare Association of Dakotas (CHAD) has been developing a growing working relationship with the American Indian community in North and South Dakota. CHAD works with the Aberdeen Area Health Indian Service and the Aberdeen Area Tribal Chairman's Health Board. Alaska PCA and PCO are working with a large number of tribal organizations in this region. The goal is to educate numerous clinics and tribal organizations about the CHC model and assist individuals interested in submitting applications.
Ongoing throughout 2006	Requirements for the development of a Section 330 health center program	HRSA staff Tribal entities	HRSA/BPHC representative met with the Eastern Shoshone and Northern Arapahoe tribes on the Wind River Reservation in Wyoming. The meeting was arranged by the PCA to discuss the requirements of the health center program and the next steps the tribes might take in pursuing grant funding. HRSA provided background information on the health center programs and discussed the requirements of the program.

Date	Event	In Attendance	Summary
Ongoing throughout 2006	Partnering and policy/programmatic issues that currently serve as barriers to high-quality primary health care for AI/ANs	Primary Care Organizations Tribal organizations in Arizona	Pecos has undertaken the health issues facing Native Americans in AZ. InFY 98/99, BPHC provided funding to AZ Association of Community Health Centers which was transferred to the Primary Care Office (PCO), to conduct planning activities in the area of primary health care for Native Americans. This initial work has created the impetus for a larger effort, involving Federal partners (HRSA and IHS), the AZ Department of Health Services, among other agencies, to address the policy and programmatic issues that currently serve as barriers to accessible, high-quality primary health care for Native Americans in AZ. The intended process involves partnership and systems development, planning and needs assessment, advocacy and technical assistance. The intended outcome is the development of a comprehensive primary care system that is responsive to the needs of Native Americans on and off reservations and can bring about improvements in health status. The system will be culturally competent and sustainable and directed towards self-sufficiency.
Ongoing throughout 2006	Arizona Primary Care Organization	HRSA staff Primary Care Organizations Tribal organizations	HRSA provided funding to the AZ PCO in the amount of $40,000 for the MOU which was formulated to formalize these cooperative efforts between HRSA, IHS, and PCO. Furthermore, three of the IHS area offices (Navajo Nation, Tucson and Phoenix) supplied an additional amount of $30,000, in support of state-level activities necessary to carry out the goals of the MOU. As a result of the MOU the PCO created a Native American program coordinator position. The coordinator is responsible for coordinating and implementing the four major points of interest covered under the MOU. (1) Resource Development; a resource directory is being developed that will inform tribal people in AZ, Urban Indians, and any facility serving

Date	Event	In Attendance	Summary
			predominately Native American people about all the resources available pertaining to health care access and facility development; (2) Advocacy; the Native American development coordinator will make available information on resources targeting Native Americans and the State/Federal legislative regulation changes that will benefit and inform the American Indian population; (3) Training and Technical Assistance; four trainings per year for any tribal community in AZ with primary focus on grants availability for the development and or expansion of access to primary care; (4) Assessment, Outreach, and Coalition building; the program coordinator will assess the primary care needs for Native Americans in AZ, as well as, conduct outreach to the twenty-one tribal health departments and the three Urban Indian health centers. Lastly, coalition building, the program coordinator will be responsible for bringing the communities together for the purpose of expanding primary care services given to Native Americans.

Date	Event	In Attendance	Summary
Indian Health Service (IHS)			
May 10-11; May 22-26, June 14-15 and July 13, 2006	IHS Tribal Management Grant (TMG) Program Training Sessions conducted regionally	TMG staff, Tribal representatives	Provide training to Tribes and Tribal Organizations (T/TO) eligible to apply for TMG program funds. Training ensured applicants had an understanding of the grant program and information on the step by step process to successfully qualify and complete the Grants.gov process mandated in FY 2006.

Date	Event	In Attendance	Summary
National Institutes of Health (NIH)			
NIH/National Heart, Lung, and Blood Institute (NHLBI)			

Date	Event	In Attendance	Summary
Item 4 8/23/2006	Reducing Health Disparities in American Indians and Alaska Natives by Preventing Diabetes Throughout the Life Cycle. National Conference in Oklahoma City	Scientists, health care practitioners, Federal government officials, community leaders, and community health workers. Dr Jared Jobe (NHLBI) organized the session.	A session of NHLBI grantees, "Changing Lifestyles to Prevent Obesity and Diabetes." was organized. A presentation, "Conducting NIH-funded clinical trials in Native communities to prevent obesity: Background." was made at the session.
NIH/National Library of Medicine (NLM)			
7/9/2006	Site Visit, Miloli'i Native Hawaiian Village, Big Island, HI	NLM Associate Director and Senior Staff, Miloli'i Village officials and residents, Papa Ola Lokahi staff	Miloli'i Village provided valuable insights on the use of health information and library services, including NLM web sites
7/12/2006	Tribal Consultation—Native Hawaiian Health and Healing Materials	NLM Associate Director and Senior Staff, 12 Native Hawaiians and others from archival, library, and museum organizations, Papa Ola Lokahi staff	Invitees provided valuable information on identification, collection, preservation, and development of relevant materials

Date	Event	In Attendance	Summary
Office for Civil Rights (OCR)			
11/9/2005	Second Annual American Indian Roundtable, Baltimore, MD	Hosted by the Maryland State Department of Health & Mental Hygiene's Office of Minority Health & Health Disparities. Attendees from the: Maryland Commission on Indian Affairs, Baltimore Medical System, Indian Health Service, Baltimore American Indian Center, State AIDS Administration, and several members of various tribes.	The purpose of the roundtable was to discuss health disparities among Maryland's American Indian communities; and its focus was on identifying the issues and devising networks and partnerships to alleviate health disparities in the Indian population in the State. OCR Region III staff provided the group with information on how OCR and HHS promote equal access to health care.
2/22/2006 & 8/14/2006	Meetings with the American Indian Community House (AICH), New York City	Approximately 10 AICH employees in the February meeting, and one AICH representative in the August meeting.	OCR Region III staff organized and participated in two meetings with AICH employees. The AICH organization (partially funded by the Indian Health Service) serves approximately 60,000 Native Americans in and around the New York City area. The services it provides include substance abuse and housing referrals, employment

Date	Event	In Attendance	Summary
			counseling, and life skills. In the February meeting, following OCR's presentation on the Office's Civil Rights and HIPAA responsibilities, AICH employees provided anecdotal information regarding alleged discrimination by local health care facilities against their clients. The OCR representative informed the attendees on how to file a complaint with us.

Date	Event	In Attendance	Summary
Substance Abuse and Mental Health Services Administration (SAMHSA)			
8/17/2006	Dear Tribal Leader Letter (DTLL)	N/A	The SAMHSA Acting Deputy Administrator sent a DTLL to tribal governments and tribal organizations responding to issues raised at the Spring 2006 DHHS Regional Tribal Consultation Meetings and providing a list of SAMHSA resources, grants information, and available technical assistance.

OTHER REGION-SPECIFIC CONSULTATION EFFORTS

Date	Event	In Attendance	Summary
Region II			
Date	Budget Consultation	All Divisions of HHS, including ANA, I.H.S., OMH, ICNAA, and more than (number) tribal leaders	Tribal leaders shared their priorities with the Department, and Department staff responded to immediate and specific tribal concerns. Policy issues ranging from (issue) to (issue) were also discussed.
Region IV			
11/27/2006	Distributed National Influenza Vaccination Week information to all regional federally recognized tribes.	Region IV Office of Minority Health	Disseminated flyers and contact information to all tribes detailing who was at risk for influenza and how to obtain information regarding vaccinations. Promoted the need to consider vaccination through the end
			of the calendar year, especially for at-risk citizens.
Region V			
Aug-06	Consultation meeting on collaboration	Region V ACF staff	Regional staff met with representatives from the Chicago American Indian Center to begin a collaborative effort to enhance service delivery to Urban Indians in the Chicago area.

Date	Event	In Attendance	Summary
Aug-06	Wisconsin State/Tribal Indian Child Welfare Partnership meeting	ACF - Krista Thomas	Upon the Partnership's request, ACF staff attended their August 2006 meeting to discuss ACF ICW funding opportunities, training and technical assistance resources, Tribal roles in the Child and Family Service Review processes, and the Fall 2006 Tribal/State/Federal Indian Child Welfare Collaborative, sponsored by ACF Region V.
Aug-06	Lac du Flambeau	ACF - Krista Thomas	Title IV-B Child Welfare programmatic site visit with Lac du Flambeau Indian Child Welfare Director. The purpose of the meeting was for Federal and Tribal staff to meet personally and discuss program outcomes, ask and answer questions, and discuss program improvements.
Aug-06	Menominee Nation	ACF - Krista Thomas	Title IV-B Child Welfare programmatic site visit with Menominee Indian Child Welfare Director and Youth Services Director. The purpose of the meeting was for Federal and Tribal staff to meet personally and discuss program outcomes, ask and answer questions, and discuss program improvements.
Aug-06	Red Cliff Band of Lake Superior Chippewa	ACF - Krista Thomas	2 site visits: Red Cliff First American Prevention Center (Healthy Marriage for Underserved Communities discretionary grant) and the Red Cliff Indian Child Welfare Program (title IV-B, subparts 1 and 2, child welfare funding). Visits assured that programs were compliant with Federal guidelines and regulations and provided Tribal and Federal staff the opportunity strengthen their partnership by personally meeting to discuss program outcomes, ask and answer questions, and discuss program improvements
8/1/2006	Consultation meeting on Technical Assistance	Region V	Region V continues to provide on-going T/TA to Tribal IV-D Start-up programs, as they develop the infrastructure for their child support programs.
Region VI			
10/5/2005	Meeting with Lawton IHS United Director for consultation on dialysis services	CMS ESRD Clinical Lead, Nephrologist, SUD, PA, 2 Internal Medicine physicians	Discussed concern raised in Regional Consultation Session regarding potential opening of a dialysis facility by IHS.

Date	Event	In Attendance	Summary
10/16/2005	22nd Annual NIHB Conference - Phoenix, AZ	3 regional CMS staff, tribal leaders, health directors, IHS Area Directors, state health departments, Trailblazer	In addition to general conference topics, CMS discussed Medicaid hot issues, presented an overview of the Medicaid and SCHIP programs, and discussed new opportunities for billing Medicare, FQHC, the all-inclusive rate, and cost reporting.
10/19/2005	Annual NAC Meeting	3 CMS RO VI staff plus staff from other CMS regions and CO	Held in conjunction with NIHB Conference
11/8-10/2005	New Mexico Independent Living Conference - Albuquerque	New Mexico Pueblos and Tribes, ACF Child Welfare staff, New Mexico Children, Youth and Families Dept. staff	Meeting sponsored by New Mexico Children, Youth and Families Dept. to increase tribal understanding and awareness of Title IV-E stipends and Independent Living programs
11/14-18/2005	Meeting with Native American Healthy Marriage/Healthy Relationship grantees	Representatives of Choctaw Nation, National Indian Women's Health Resource Center, and Citizen Potawatomi Nation; ACF 's Tribal staff	Met with tribal administrators responsible for the implementation of newly funded ANA grants in support of Healthy Marriages/Healthy Relationships to develop a delivery mechanism and workable agreement for mutual information dissemination, technical assistance, and monitoring. Additional information on leveraging resources, upcoming ACF funding opportunities, and technical assistance was delivered.
11/14-18/2005	Meetings with Cherokee Nation, Osage Nation, Comanche Nation	Tribal Administrators and Program Managers of the Cherokee Nation, Osage Nation, Comanche Nation; ACF staff	Discussed status of Tribal Child Support "Start-Up" programs and emerging issues related to developing service delivery programs including medical support with the Cherokee Nation and the Osage Nation and provided information on writing a successful Tribal Child Support "Start-Up" application to representatives of the Comanche Nation. Additional information on leveraging of resources, upcoming ACF funding opportunities, and technical assistance was delivered

Date	Event	In Attendance	Summary
11/15/2005	Meeting with Comanche Nation – Dallas, Texas	Representatives of Comanche Nation; Federal ACF staff	Representatives from the Comanche Nation traveled to Dallas to meet with Federal staff to discuss Tribal child care issues. The Comanche Tribe recently assumed operation of a child care center previously operated by Comanche Nation Housing Authority. The Regional Office and Tribal representatives discussed leveraging resources to lease the facility and administer center-based child care services. In addition, the Regional Office provided information on literacy, language preservation, fatherhood, and healthy marriage to enhance services provided by the Tribal child care program.
11/17-18/2005	Oklahoma Annual IV-E Tribal-State Meeting – Oklahoma City, Oklahoma	Oklahoma Title IV-B-1 & 2 grantees with Title IV-E Tribal-State agreements, representatives Oklahoma Department of Human Services, ACF Child Welfare staff	This meeting was sponsored by the Oklahoma Department of Human Services (DHS) in order to increase tribal understanding and awareness of the Title IV-E tribal-state agreements as well as to provide other opportunities for partnerships such as through IV-E stipends and Independent Living programs.
3/7-10/2006	Oklahoma Tribal Child Care Administrators Training	Oklahoma Tribal Child Care Administrators	The objectives of the training were to provide the Oklahoma Tribal child care administrators with an overview of Tribal child care related updates, resources, and technical assistance. In addition, the Oklahoma State Child Care Administrator discussed collaboration and information sharing with the Tribal child care programs. This was an excellent forum to both share and gather information for the planning and agenda development for the National
			State/Tribal conference in August. Twenty-seven of thirty-four Tribal child care grantees attended the meeting.
3/12/2006	Meeting with Cherokee Nation – Tahlequah, Oklahoma	Cherokee Nation Social Services staff and representatives from Legal and Finance Departments; ACF Tribal TANF/Child Support staff	Continued ongoing discussions regarding requirements of the Tribal TANF program as the Cherokee Nation continues to explore feasibility of direct funding and discussed implementation status of their Tribal Child Support "Start-Up" Program. Additional information on leveraging of resources; upcoming ACF-funding opportunities and

Date	Event	In Attendance	Summary
			technical assistance was delivered.
3/13-17/2006	Meeting with Osage Nation – Pawhuska, Oklahoma; Kaw Nation –Ponca City, Oklahoma; and the Comanche Nation – Lawton, Oklahoma	Tribal Administrators and Program Managers of Osage Nation, Kaw Nation and Comanche Nation, ACF Tribal Child Support staff	Discussed status of the Osage Nation Tribal Child Support "Start-Up" Program and delivered technical assistance on writing grant applications with representatives of the Kaw Nation and Comanche Nation interested in pursuing a Tribal Child Support program. The Kaw Nation and Comanche Nation were subsequently approved for Tribal Child Support "Start-Up" funding.
3/16/2006	Meeting with Ponca Tribe of Oklahoma – Ponca City, Oklahoma	Ponca Tribe – Tribal Administrator, key government officials including tribal planner and representatives of the Fiscal Department, ACF Tribal Child Support Staff	Met with tribal officials in anticipation of their approved Tribal Child Support "Start-Up" grant and subsequent project development. ACF staff defined "technical assistance" and monitoring concepts related to the funding terms and conditions. Additional information on leveraging of resources; upcoming ACF-funding opportunities and technical assistance was delivered.
4/26/2006	New Mexico Tribal Child Care Administrators Meeting – Albuquerque, NM	Tribal Child Care Administrators, ACF Child Care staff	The objectives of the meeting were to provide the New Mexico Tribal child care administrators with an overview of Tribal child care related updates, resources, and technical assistance. This meeting was held in conjunction with the 2006 HHS Region VI Tribal Consultation. This was also an excellent forum to both share and gather information for the planning and agenda development for the National State/Tribal conference in August. Nine of fourteen Tribal child care grantees attended the meeting.
5/1-4/2006	Bi-Regional Tribal Child Care Conference	Region VI Tribal Child Care Administrators, Directors and providers, ACF Child Care staff	The training conference is part of the Region VI & VIII strategy to strengthen programs by bringing together the administrative, fiscal and programmatic representatives to promote and achieve better service delivery focusing on Tribal children, families and communities. This joint meeting was attended by approximately 100-125 Tribal Child Care professionals who work in the 82 Tribal CCDF programs within the two regions (56 in Region VI and 26 in Region VIII) including administrators, directors and providers. Since 2004, Region VI

Date	Event	In Attendance	Summary
			and VIII partnered with the National Indian Child Care Association (NICCA) and jointly developed and delivered a very successful conference focusing on the social, emotional and physical issues that impact Tribal child care settings and this has continued to be very well-received by the participants. As a result of this partnership, Tribal child care programs had the unique opportunity to participate in a series of health and safety workshops presented by nationally- and internationally-recognized early childhood experts.
5/9/2006	Meeting with Peoria Tribe of Oklahoma	Representatives of the Peoria Tribe of Oklahoma, ACF staff	Representatives from the Peoria Tribe of Oklahoma traveled to Dallas to meet with Federal staff to discuss applying for Tribal child care funds. The Regional Office participated in a three conference calls to provide technical assistance and support to the Tribe as an application was developed and submitted. The Peoria Tribe has subsequently submitted an approved application to receive Tribal child care funds for FY 2007.
5/3/2006	Dear Tribal Leaders Letter	Letter distributed to tribal leaders and health directors, tribal organizations, and Urban Indian Centers	Letter provided information on how tribes can be reimbursed for payments made to Prescription Drug Plans on behalf of tribal members
5/3/2006	Dear Tribal Leaders Letter	Letter distributed to tribal leaders and health directors, tribal organizations, and Urban Indian Centers	Letter provided guidance about the Medicare Prescription Drug Coverage and information to resolve beneficiary complaints regarding Medicare Part D Prescription Drug Plans
6/2/2006	First Nations Community Heath Source – "All My Relations" Graduation Ceremony held at the All Indian Pueblo Cultural Center, Albuquerque, New Mexico	Dr. Linda Son-Stone, Director; Merle Botone, All My Relations Program Manager; 15 Native American couples representing surrounding Pueblos and the Navajo Nation; ACF Tribal staff	Celebration of the completion of a ten-week healthy marriage/healthy relationship training course by 15 couples. Ceremony included a traditional marriage blessing of each couple. This was an ACF/Administration of Native Americans funded project.

Date	Event	In Attendance	Summary
6/19-22/2006	Annual Meeting of States and Tribes: "Many Paths, One Direction: Strategies for Achieving Lasting Reform in Child Welfare" – Washington, D.C.	State child welfare directors, Child welfare directors from the largest metropolitan area in each state, State CFSR coordinators, Tribal Representatives, Court Improvement Program representatives, State Liaison Officers, Representatives of national organizations involved with child welfare services, and ACF central and regional office staff.	This conference explored the many paths that States and Tribes have taken as they have worked to strengthen their child welfare systems – honoring what is best in their systems, while creating innovative approaches to address new challenges. This important event brought together invited policy makers, State, local, and Tribal child welfare directors and administrators, judges and court improvement personnel, State Liaison Officers, Federal staff, representatives of national organizations, and other partners. Representatives of the Court Improvement Program met the day before the conference to discuss common challenges and share solutions.
7/10-14/2006	Meeting with Cherokee Nation – Tahlequah, Oklahoma and Osage Nation – Pawhuska, Oklahoma	Tribal Child Support Administrators and Research and Development staff; ACF tribal child support staff	Discussed status of Tribal Child Support "Start-Up" Programs focused on development of policy and procedures and emerging issues related to the overall development of service delivery programs including development of office automation and the potential for a federally-funded tribal child support system. Additional information on leveraging of resources; upcoming ACF-funding opportunities and technical assistance was delivered.
7/24-28/2006	Meeting with Pueblo of Zuni – Zuni, New Mexico and the Mescalero Apache Nation – Mescalero, New Mexico	Pueblo of Zuni Chief Judge and Judiciary staff; representatives of the Mescalero Apache Nation Prosecutor's Office, Comptroller and Fiscal Department; ACF tribal child support staff	Discussed status of Tribal Child Support "Start-Up" Programs focused on development of policy and procedures and emerging issues related to the overall development of service delivery programs including development of office automation and the potential for a federally-funded tribal child support system. Additional information on leveraging of resources; upcoming ACF-funding opportunities and technical assistance was delivered.

Date	Event	In Attendance	Summary
8/29-9/1/2006	Meeting with Ponca Tribe of Oklahoma – Ponca City, Oklahoma; Muscogee (Creek) Nation – Okmulgee, Oklahoma; Kaw Nation – Kaw City, Oklahoma; and the Comanche Nation – Lawton, Oklahoma	Child Support officials of the Ponca Tribe of Oklahoma; the Attorney General and Chief Judge of the Muscogee (Creek) Nation; Child Welfare Director of the Kaw Nation and the Tribal Administrator of the Comanche Nation with ACF Tribal Child Support staff	Discussed status of Tribal Child Support "Start-Up" Programs focused on development of policy and procedures, use of federal funds and emerging issues related to the overall development of service delivery programs including development of office automation and the potential for a federally-funded tribal child support system. Additional information on leveraging of resources; upcoming ACF-funding opportunities and technical assistance was delivered.
9/16-19/2006	National Indian Council on Aging Conference - Tulsa, OK	RO VI and CO CMS staff	CMS provided an information booth and discussed various topics, including Medicare Prescription Drug Coverage, with attendees
9/19-20/2006	Financial Management for Tribal CCDF Programs	Region VI and VIII Tribal Child Care Program and Financial staff, ACF Child Care and Financial staff	Region VI and VIII Tribal child care specialists recommended and provided consultation for a two-day tribal cluster training to offer participants practical information related to child care budget preparation and tracking; evaluation of fiscal performance; determining fixed and variable costs, marginal costs, and cost allocations; and federal regulations related to grants management. These cluster training sessions were designed for tribal CCDF administrators, tribal fiscal staff, and other staff with responsibility for tribal CCDF program finances.
Region VII			
October 31-Nov 1, 2006	CERC Training	Jeff Frederick, Iowa Tribe of Kansas & Nebraska, David Hogner, HIS, Thomas Morgan, Omaha Tribe of Nebraska, Lester Randall, Kickapoo Tribe of Kansas	Crisis and Emergency Risk Communication on the Pandemic Influenza

TRIBAL CONFERENCES AND SUMMITS

In addition to the consultation sessions facilitated and led by HHS, there are a number of Tribal conferences and summits that occur throughout the year at the regional and national levels, organized by Tribal Groups and Organizations, such as the National Congress of American Indians (NCAI) and the Tribal Self-Governance Advisory Committee. This report shares information about meetings in which HHS leadership were invited to participate and speak.

Date	Event	In Attendance	Summary
Centers for Disease Control and Prevention			
May 18, 2006	HHS Tribal Pandemic Flu Summit	CDC Staff, IGA and HHS national and regional Staff, Tribal leaders, Regional and National Tribal Organizations.	Focused on identifying, framing and examining issues surrounding a coordinated response and plan for Pandemic flu in tribal nations.

Date	Event	In Attendance	Summary
Region IV			
July 10-12, 2006	Region IV Child Care State/Tribal Adm Mtg	ACF Region IV Child Care Staff and Unit manager; State and Tribal CC Managers and early care & education partners	Tribal-State Planning for next steps in ACF Region IV multi-year effort to promote Tribal-State collaboration around the Good Start, Grow Smart early learning initiative
August 7-9 2006	Child Care Bureau National Conference: *Diverse Perspectives-Common Goals*	Child Care Bureau Mgt & Staff, Child Care Staff and/or Mgt from each ACF Region, State and Tribal Adms and /or Staff from 10 ACF Regions, and others in early care and education community	At the conf, Region IV CC specialist hosted meeting of Region IV Tribal & State CC Adms on incorporating GSGS elements in tribal child care programs.
Region V			
Nov. 2, 2006	Partnership to Address the Mental Health Needs of Native Youth	SAMHSA, IHS and Bemidji-area tribes (ROV RD provided funding)	Children's Mental Health Issues. SAMHSA and IHS staff presented/facilitated.
May-06	MI Tribal/State an Infectious Disease Symposium/Tabletop Exercise	ROV OIG, CDC, MI tribes, State/county health depts., local hospital	Regional OIG attorney responded to quarantine and EMTALA questions raised at a tabletop exercise.
Aug-06	Midwest Alliance of Sovereign Tribes (MAST) - Summer meeting	ACF- Krista Thomas, Carolyn Wilson- Hurey	MAST invited ACF staff to address Tribal leaders about ACF programs and funding opportunities, specifically related to child welfare, and to discuss the agenda of Region Vs first Indian Child Welfare Collaborative scheduled for September 2006.
June 15-16, 2006	Minnesota State Tribal Meeting.	Tou-Fu Vang (ACF), Kathy Penak (ACF), Terry Davis (ACF), Susan Rohrbough (NCIC), Red Lake Band, White Earth Ojibwe, Minnesota Tribal Early Childhood Care, Leech Lake Services, Boise Forte Tribe,	Topics of Discussion included: Child Care, School Readiness, Data Tracker, Social & Emotional Development and Fiscal Issues of Reporting and Receiving Federal Funds. The Fiscal Session was facilitated by Region V, ACF staff (Terry Davis). Region V, ACF staff, Kathy Penak and Tou-Fu Vang both provided greetings and information at this meeting.

Date	Event	In Attendance	Summary
August 29-31, 2006	Future Search: Tribal Early Care	Gena Miller (ACF), Susan Rohrbough (NCCIC), Susan Lightle (Indiana Head Start Collaboration), Nancy Willyard (Michigan Head Start Collaboration) Eva Carter (NCCIC), Phillip Printz (CSEFL), Nina Stanton (Tri-Tech) Sault Ste. Marie Tribe of	This meeting included preparation and planning for future collaboration between the State and Tribal Communities specifically with a focus on Child Care and Early Childhood Education. Topics of Discussion included: IDEA Affects Tribal Special Education Programs, Leadership Strategies for Supporting Children's Social and Emotional Development, The first two days were moderated by members of NCIC and TriTech Staff, The final day was moderated by Region V, ACF Staff (Gena Miller).
8/1/2006	Co-Hosted Tribal Summit	Region V ACF Child Support staff	Co-hosted with Region VII a Bi-Regional Tribal IV-D Summit geared to enhance programmatic efficiencies between Tribal IV-D programs and States as well as providing newly funded Tribal IV-D programs with information on Child Support Enforcement program development.
09/11-13/06	Tribal TANF Symposium	Central Office OFA Staff, Region V ACF Staff, 9 Tribal TANF grantees, 2 Non-Tribal TANF Tribes, MNDHS Staff, WIDWD Staff,4 Tribal ACF Grantees resource presenters	Tribal TANF grantee-staff from the Region received training and technical assistance on program planning; management , administration, coordinating services and programs; and special issues such as healthy Marriage, Transportation, etc.
9/1/2006	Technical Assistance	Region V ACF staff	Made available and distributed surplus ACF computer equipment to regional Tribal governments.
Region VI			
2006	Intra-Agency Tribal Issues Workgroup	Members include individuals from the ORD, ACF, AoA, CMS,HRSA, OCR, IHS Area Offices, USET, other Tribal organizations	Quarterly meetings are held with the HHS Regional Director presiding. Each agency has a representative that attends. Tribal groups or organizations in Region VI that participate call in. Each meeting includes Department updates (such as Deputy Secretary will visit Oklahoma Tribes), agency presentation (during each meeting a representative will provide a brief overview of their agency and how it may involve the Tribes), and other business. The mission is to increase communication among Region VI HHS agencies in order to educate one another about tribal issues, to collaborate as "one department on

Date	Event	In Attendance	Summary
			tribal projects and initiatives, and to identify tribal services needs in order to better serve Native American people in Region VI."
10/17/2006	Oklahoma City Area Inter-Tribal Health Board Meeting	IHS OKC Area Office and representatives from tribes served by that office; Michael Garcia and Don Perkins from HHS	RD Michael Garcia and EO Don Perkins attended regular meeting to hear tribal issues and report on HHS Regional Office activities.
5/3/2006	Tribal Pandemic Flu Summit	HHS, Tribal Representatives	Acting RD Don Perkins attended
Region VII			
November 28-29, 2006	Aberdeen Area Tribal Chairmen's Health Board	IGA Specialist Hughey	Indian Healthcare Improvement Act, Indian Health Policy & Financing, 3rd Party Billing, Unintentional Injuries, NARCH, Meth, Suicide, Strategic Long Range Planning, Keynote address by Dr. Charles Grimm, Assistant Surgeon General, Health Promotion, and Budget Process
Region X			
October 26, 2005	Northwest Portland Area Indian Health Board	Region 10 RD	Spoke at the quarterly meeting in Grand Ronde, OR and participated in their session on Medicaid.
December 1, 2005	ACF's Government to Government Forum: A Perspective in Tribal Law & Relationships	Region 10 RD	Participated in the forum.
December 2, 2005	American Indian Health Commission for Washington State	Region 10 RD	Participated in the quarterly meeting.

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Section 3
Outcomes and Accomplishments

SECTION 3: OUTCOMES AND ACCOMPLISHMENTS

MAJOR HHS OUTCOMES AND ACCOMPLISHMENTS

National Tribal Leaders Pandemic Influenza Preparedness Summit
In 2006, Secretary Leavitt requested every state and territory host a pandemic influenza preparedness summit. Due to the government-to-government relationship the federal government has with tribes, and the strong tribal interest in a pandemic flu summit, the Secretary hosted the *Tribal Pandemic Influenza Summit* in Washington, D.C. on May 18, 2006. The agenda for the day included discussion by tribal experts and representatives from state and local health departments who discussed how tribes, HHS and States work together to prepare and respond to threats to Tribal Communities. The White House representative was Dr. Rajeev Venkayya, Special Assistant to the President for Biological Defense Policy, other Federal Departments included Department of Homeland Security, U.S. Geological Survey, U.S. Department Agriculture and Smithsonian Institution.

The four Tribal leaders tasked with leading the discussions were Buford Rolin, Vice Chairman National Indian Health Board, Don Kashaveroff, Chairman tribal Self Governance Advisory Committee, H. Sally Smith, President National Indian Health Board and Jefferson Keel, 1st Vice President National Congress of American Indians.

Methamphetamine Abuse in Indian Country
In 2006 HHS hosted a series of Roundtable discussions in conjunction with the regional Tribal consultation session that focused on methamphetamine (meth) abuse in Indian Country. As a result of the overwhelming responses and stories HHS worked to award $1,175,100 for outreach and education needs of Tribal Communities as they address meth abuse. This initiative identifies a two-pronged approach, including a national education and information outreach campaign and a series of knowledge transfer activities that would help communities understand promising practices in combating methamphetamine abuse. It brings federal, tribal, state, and local resources together to reach urban and rural Native American communities and families. The Association of American Indian Physicians will partner with: Oregon Health and Science University-One Sky Center, Portland, OR, National Congress of American Indians, Washington, DC, United South and Eastern Tribes (USET), Nashville, TN., Northwest Portland Area Indian Health Board (NPAIHB), Portland OR. As well as the following five Tribes: Choctaw Nation, Crow Nation, Navajo Nation, Northern Arapaho Tribe, and Winnebago Tribe.

American Indian/Alaska Native Health Research Advisory Council Meeting
In 2006, HHS agencies partnered with Tribes to develop the HHS AI/AN Health Research Advisory Council. The Advisory Council is made up of 12 representatives from the Indian Health Service Areas as well as the 4 national Tribal Organizations. The Council will develop Tribal Priorities; work with HHS representatives to advise the Department on the best way to consult with Tribes on research issues. The Advisory Council met twice in 2006 once in Washington, DC and once in Albuquerque, NM. HHS agencies that are involved in this effort are Office of Intergovernmental Affairs, Indian Health Service, Agency for Healthcare Research and Quality, National Institutes of Health, Centers for Disease Control and the Assistant Secretary for Policy and Evaluation and the Office of Minority Health has the lead for Advisory Council.

Regional Tribal Consultation Sessions In 2006, HHS Regional Directors coordinated their 3rd Annual Regional Tribal Consultation Sessions. Six sessions total were held with Regions 1-4 hosted a joint

session in conjunction with the United South and Eastern Tribes Organization since all of these area Tribes belong to on regional tribal Organization. Results of these sessions are documented in this report.

1st Annual National Divisional Tribal Budget Consultation Session On March 10, the Department hosted the 1st Annual National Divisional Tribal Budget Consultation Session at HHH. Over 100 tribal and federal representatives attended. Assistant Secretary Charles Johnson, IHS Director Chuck Grim, ANA Commissioner Quanah Stamps hosted the daylong event which included testimony and discussion involving health and human services budget priorities and policies issues of interest to Indian Country. Tribal comments about the day's session were constructive and positive. AS Johnson was applauded for being at the session at the end of the day to ensure he heard the Tribal Leaders summation and closing remarks.

8th Annual National HHS Tribal Budget Consultation Session
On May 16 -17, 2006 HHS hosted the 8th Annual National HHS Tribal Budget Consultation Session. The purpose of the May session is to provide Tribal and HHS leadership the opportunity to discuss health and human services funding priorities and budget recommendations. HHS leadership utilized input received to review Agency budget requests to ensure that the concerns of Tribal Leaders were taken into account as the Department prepared for the FY 2008 budget request to be submitted to the Office of Management and Budget in September. HHS attendees included the Deputy Secretary Alex Azar, Assistant Secretary for Resources and Technology, Indian Health Service Director Charles Grim, Office of Intergovernmental Affairs Director Jack Kalavritinos and the representatives of the Secretary's Budget Council. The Session was attended by well over 100 Tribal Leaders and participants.

Improved Tribal Access to HHS Resources
In 2006, HHS resources that were provided to Tribes or expended for the benefit of Tribes increased to approximately $4,825.37 billion, an increase of approximately $164.46 million over the 2005 amount of $4,660.92 billion. These gains came in both appropriated funding as well as increased Tribal access to non- earmarked funds and increases in discretionary set asides.

The following section is divided into 4 headings, Regulation, Policy, Legislation and Budget and Divisions and Regions are grouped together under each heading.

DIVISION OUTCOMES AND ACCOMPLISHMENTS

Agency for Toxic Substances and Disease Registry (ATSDR)

Priority #3: Health Promotion and Disease Prevention:

ATSDR released the following reports at the request of Tribes:

- Evaluation of Biota Data Collected in the Vicinity of Tyonek, Seldovia, Port Graham, and Nanwalek, Alaska
- Penobscot River, Maine, Public Health Consultation
- Hopi Dip Vats Public Health Consultation
- Yerrington Anaconda Mine Site Public Health Consultation
- Navajo Dip Vats Public Health Consultation

These reports provide vital information for the Tribes to make decisions related to the potential for harm to their people via exposures to environmental contaminants. The reports also provided recommendations for the Tribes for health promotion and behavioral changes to prevent disease. The agency's work with the Native Villages in the Cook Inlet region of Alaska has focused on tribal concerns about contamination of traditional foods by local pollution sources and by global migration of contamination via the marine and air currents into the Arctic region. Benefits of those foods for a healthy lifestyle are included while defining any risk from exposures.

Priority #4: Recruitment and Retention of Healthcare Providers:

During this Fiscal Year, ATSDR released new 5-year funding for the Cooperative Agreement Program to Build Capacity and to Conduct Site-Specific Activities. Recipients included:

- Gila River Indian Community
- Alaska Native Tribal Health Consortia and Alaska Division of Public Health

ATSDR is also funding cooperative agreements with Tribal Colleges and Universities (TCUs). Accomplishments within the TCU agreements are focused on building degreed programs for tribal students in environmental public health. Key accomplishments include:

- An MOU between Dine' College and The Institute for Public Health University of New Mexico – to have personnel collaborate and share resources for the purpose of developing public health training programs on the Navajo Nation; to advance the implementation of the existing Associate of Science degree program in the Public Health at Dine' College and contribute to the formalization of educational and training requirements for workforce development, including graduate education, within the Navajo Nation Division of Health.

Centers for Disease Control and Prevention (CDC)

- **Tribal Priorities #1 and #2, Funding and Related Issues, and Increased Access to CDC Programs**

CDC/ATSDR Tribal Consultation Policy
This policy, officially released early in FY 2006 (October18, 2005), describes steps that CDC programs should take toward working effectively with AI/AN communities and organizations. The policy identifies when CDC programs should involve tribal leaders and outlines specific responsibilities regarding program activities, including mutual participation in setting program and budget priorities. The policy also provides guidance on

enhancing AI/AN access to CDC programs and resources, including those awarded to State health departments. As a result of the policy, CDC is consulting more effectively with tribes and is receiving helpful tribal input on a broad range of issues that include the development of new program announcements, implementation of new or ongoing public health programs, and the fostering of stronger partnerships between tribes and other CDC partners such as state health departments and academic institutions. Implementation of this policy across CDC and ATSDR is ongoing and the implementation process has been enhanced by the establishment of the CDC/ATSDR Tribal Consultation Advisory Committee (TCAC).

The TCAC was established as an advisory committee to the CDC Director and ATSDR Administrator in order to provide a complementary venue wherein tribal representatives and CDC staff would exchange information about urgent public health issues in Indian country and collaborate on approaches to address these issues and needs. The TCAC assists in strengthening CDC partnerships with tribes and tribal organizations, and in planning and coordinating upcoming tribal consultation sessions. The TCAC also provides enhanced connectivity between CDC and tribal leaders through their regional health boards and the National Indian Health Board. This connectivity will help to ensure that CDC activities or policies that impact Indian country are brought to the attention of tribal leaders as well as CDC senior leadership. The TCAC Charter is attached as Appendix One. The CDC/ATSDR Tribal Consultation Policy and related documents are available at: http://www.cdc.gov/omh/TCP/TribalConsultation.htm and http://www.cdc.gov/omh/TCAC/TCAC.html.

Tribal Access to CDC Programs and CDC AI/AN Resource Allocations

CDC's Tribal Consultation Policy also helps to assure tribal eligibility for CDC program announcements. In FY 2006, CDC funded 69 cooperative agreements to 50 tribal partners (tribal governments, tribal health boards, tribal organizations, Alaska Native health corporations, urban Indian health centers, and tribal colleges) across 19 states (see Appendix Two). Total funds allocated through competitively awarded grants and cooperative agreements exceeded $22.0 million. Compared to FY 2005, although total funding in this category decreased by about $500 thousand, the number of awardees remained the same and the total number of awards increased from 58 to 69 (19 percent increase).

In addition to grants and cooperative agreements awarded to tribal partners, CDC also allocated more than $8.5 million through grants/cooperative agreements awarded to state health departments and academic institutions for programs focusing on AI/AN public health issues. The remainder of CDC's AI/AN portfolio falls into three categories: (1) intramural resources (about $8.5M), (2) federal intra-agency agreements (about $2.8M), and (3) indirect allocations ($51.8M). The indirect category primarily represents resources devoted to immunizing AI/AN children through the Vaccines for Children (VFC) program.

If indirect funds are included, CDC estimates its total FY 2006 resource allocation for AI/AN programs to be approximately $93.9 million, 23 percent of which goes directly to tribal partners and 88 percent overall is expended outside of HHS. The total figure ($93.9M) represents a 36 percent increase over AI/AN allocations in FY 2005.

If indirect funds are not included, CDC estimates its total FY 2006 allocation for AI/AN programs to be approximately $42 million, 53 percent of which goes directly to tribal partners and 73 percent overall is expended outside of HHS. The total figure ($42M) represents a 3.2 percent increase over AI/AN allocations in FY 2005.

The resource allocation categories are defined as follows:

1. **AI/AN Awardee:** Competitively awarded programs (i.e., grants, cooperative agreements) where the awardee is a tribe, tribal health board or coalition, tribal organization, Alaska Native organization, urban Indian Health program, or tribal college/university.
2. **Extramural AI/AN benefit**: Competitively awarded programs where the purpose of the

award is to primarily or substantially benefit AI/ANs; however, the awardee is not a tribal organization as defined in #1 above (e.g., state health departments, academic institutions). (*"primarily or substantially" is defined as 50 percent or greater devotion of funds/efforts).*

3. **Federal AI/AN benefit:** Federal Intra-Agency Agreements where the purpose of the agreement is to primarily or substantially benefit AI/ANs (e.g. with IHS).

4. **Intramural AI/AN:** Intramural programs whose purpose is to primarily or substantially benefit AI/ANs; this category includes costs (e.g., salary, fringe, travel, etc.) associated with CDC staff or contractors whose time/effort primarily or substantially benefit AI/ANs.

5. **Indirect AI/AN:** Service programs where funding for AI/ANs can reasonably be estimated from available data on the number of AI/ANs served. This category primarily reflects the Vaccines for Children program, where the amount of funding benefiting the AI/AN population is reasonably estimated by taking the proportion of clients served who identify themselves as AI/AN via patient encounters, and applying that proportion to the total funding for the program.

Tribal Priority #3, Health Promotion and Disease Prevention

Diabetes: "Eagle Books"

The Eagle Books are a series of four books brought to life by wise animal characters—Mr. Eagle and Miss Rabbit—and a clever trickster, Coyote, who engage Rain That Dances and his young friends in the joy of physical activity, eating healthy foods, and learning from their elders about health and diabetes prevention. The Eagle Books were authored by Georgia Perez of Nambe Pueblo; illustrated by Patrick Rolo, Bad River Band of Ojibwe, and Lisa A. Fifield, Oneida Tribe of Wisconsin, Black Bear Clan. Reaching young people, particularly in the school setting where they are spending 6-9 hours a day, presents an opportunity to help improve the health outcomes of the nation's youth, which, in turn, can have positive effects on intermediate and long-term social, educational, and economic outcomes. The Eagle books and the efforts of CDC's Native Diabetes Wellness Program, in partnership with the Indian Health Service (IHS) and the Tribal Leaders Diabetes Committee (TLDC), are putting those ideas into action by bringing to teachers, parents, and students important health promotion messages to help children grow safe and strong -- messages like good nutrition and regular physical activity. In 2006, the CDC Native Wellness Program distributed almost 1 million Eagle Books to American Indian and Alaska Native health and school organizations through partners including First Book and the Indian Health Service Division of Diabetes Treatment and Prevention. The books draw interest outside of Indian country. One teacher called them "an ambassador of hope" to Native communities and other communities who want to learn more about Native peoples, health wisdom, diabetes, and who appreciate the tradition of storytelling. For more information on the Eagle Books series see: First Book National Book Bank or call 1-866-393-1222. Free single copies may be obtained from CDC by calling: 1-800-CDC-INFO.

Diabetes: National Diabetes Education Program

The National Diabetes Education Program (NDEP), a joint initiative between CDC and NIH, has created an extensive partnership network to mobilize public and private sector organizations to work with the NDEP to improve the way diabetes is treated. An AI/AN Workgroup was formed to assist with the development of culturally appropriate TV, radio, and print ads for American Indian communities. With input from tribal leaders and community members, the campaign message became, "Control your Diabetes for Future Generations." In addition, the Association of American Indian Physicians (AAIP) was selected by CDC to help disseminate campaign materials. The American Indian/ Alaska Native Workgroup developed a campaign focused on youth called "Move it!" The AIAN workgroup developed another campaign for adults at risk for diabetes, "We have the power to prevent diabetes."

Cancer

In FY 2006, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funded 13 AI/AN tribes and tribal organizations

among its 68 grantees. NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. About 57 percent of screenings provided by the National Program were to women from racial or ethnic minority groups. Approximately 4.2 percent are AI/AN women.

The National Comprehensive Cancer Control Program (NCCCP) is a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients**.** With approximately $15 million in appropriations in fiscal year 2006, CDC provided support for building coordinated and priority-driven cancer control programs in all states, the District of Columbia, six tribes and tribal organizations, and six U.S. Associated Pacific Islands/territories. With this support, health agencies continued to establish broad-based CCC coalitions, assessed the burden of cancer, determined priorities for cancer prevention and control, and established the infrastructure necessary to develop and implement CCC plans.

Tobacco

For the past 5 years OSH has funded 7 Tribal Support Centers to build capacity and infrastructure in "Indian country" to prevent and control the non-traditional uses of tobacco among American Indians and Alaskan Natives. The Support Centers provide technical assistance and consultation directly to tribes and organizations that work with tribes about culturally competent approaches to working with AI/ANs as they develop educational messages and policies to reduce tobacco use among native people.

- **Tribal Priority #5, Emergency Preparedness**

In FY 2006, $4,116,244 of states' cooperative agreement funds were disseminated to tribal nations, IHS, and tribal organizations in the form of grants, contracts, and dedicated staff. An additional $58,469,939 dollars was distributed to local health departments and other contractors for local-level activities and training that could reasonably be expected, in part, to contribute to the preparedness of Indian country by engaging American Indians and Alaska Natives in planning and exercises. These funds, however, are not identified specifically in the state budgets as serving Indian country.

- **Tribal Priority #6, Data and Research**

International Indigenous Health Measurement

CDC's National Center for Health Statistics, with assistance from the CDC National Center for Chronic Disease Prevention and Health Promotion and Office of Minority Health and Health Disparities, organized an international collaboration to focus on improving the measurement of health status in indigenous populations in the U.S., Canada, Australia, and New Zealand. This group, known as the International Group for Indigenous Health Measurement, held its first meeting in Vancouver, Canada from October 1 – 5, 2005 and its second meeting in Canberra, Australia, from November 28 – 30, 2006. In addition to CDC staff, the U.S. delegation included representatives from Tribal and Urban Indian Epidemiology Centers, a tribal health director, a University-based AI/AN researcher, and IHS. The group includes government representatives, researchers and representatives of Indigenous organizations from the four countries. Proceedings from the first meeting have been published, and proceedings from the second meeting are in preparation. In addition, representatives are preparing summaries of indigenous health statistics for each country that will be made broadly available. Details of the Canberra meeting are available at: http://www.aihw.gov.au/eventsdiary/igihm06/index.cfm

In-home Water Availability and Infectious Diseases Among Alaska Natives

Challenges to bringing modern sanitation services (i.e., potable drinking water and safe wastewater disposal) to homes to remote Alaskan villages include harsh climate, small and sparse populations, geographic isolation and

limited resources. Approximately 60% of Alaska Natives live in about 220 rural villages, the majority of which have populations of less than 300 people. In 2000, only 77% of Alaskan homes had sanitation services. To better understand the relationship between in-home water and wastewater service and the risk of infectious disease in rural Alaska, a number of projects were implemented. The projects are a collaborative effort between the Artic Investigation Program, Alaska Native Health Consortium, Indian Health Service, and CDC/DVRD. Data collected for these projects included: data on the level of water and wastewater service to homes in rural Alaska (source: Rural Alaska Housing Sanitation Inventory conducted from July 2001 through April 2004); hospital discharge data for 2000-2004 and population data for AI/ANs (sources: IHS Direct and Contract Health Service inpatient dataset); infectious disease hospitalizations in Alaska (diarrhea, pneumonia/influenza, skin/soft tissue infection and methicillin-resistant *Staphylococcus aureus* (MRSA) (sources: IHS Direct and Contract Health Service inpatient dataset). Using these data, average annual hospitalization rates were calculated by region of residence. Age-specific rates were also calculated, and risk ratios were calculated for comparison of the hospitalization rates by water service level. Findings included the following:

- Twenty-four percent of infants in Alaska villages with minimal or no water service are hospitalized for pneumonia.
- Low water service areas had three times the incidence of pneumonia and influenza and twice the rate of skin infections compared to high water service areas.
- These data directly influenced the decision to continue federal funding for the Village Safe Water program that aims at bringing running water and sanitation services to rural villages in Alaska – a program that had been targeted for a 75% decrease in funding.

Pneumococcal Disease in Alaska Native Infants and Children

CDC's AIP continues to conduct research and public health activities that focus on preventing pneumococcal disease in AN infants and children. AIP has helped to document a 90 percent decrease in invasive pneumococcal disease among AN infants and children after introduction of pneumococcal conjugate vaccine. This has eliminated the longstanding health disparity for vaccine-type disease among Alaska Native children. Ongoing surveillance has established that use of this vaccine has resulted in a decrease in antimicrobial resistant pneumococcal infections and an indirect effect of decreased pneumococcal disease in adults resulting from decreased transmission of pneumococci.

Selected Data Highlights from CDC's National Center for Health Statistics

http://www.cdc.gov/nchs/data/series/sr_10/sr10_228.pdf

Selected CDC Publications on AI/AN Health Issues, 2006

Amon JJ, Darling N, Fiore AE, Bell BP and Barker LE. Factors associated with hepatitis A vaccination among children 24 to 35 months of age: United States, 2003. *Pediatrics* 2006;117;30-33.

Demma LF, Holman RC, Mikosz CA, et al. Rocky mountain spotted fever hospitalizations among American Indians. *Am J Trop Med Hyg.* 2006;75(3):537-41.

Doshi SR, Jiles R. Health behaviors among American Indian/Alaska Native women, 1998-2000 BRFSS. *Journal of Women's Health.* 2006;15(8):919-27.

Groom AV, Cheek JE, and Bryan RT. Effect of a national vaccine shortage on vaccine coverage for American Indian and Alaska Native children. *Am J Public Health*. 2006;96:697-701.

Singleton RJ, Holman RC, Cobb N, Curns AT, Paisano, EL. Asthma hospitalizations among American Indian and Alaska Native people and for the general U.S. population. *Chest*. 2006;130:1554-1562.

Singleton RJ, Hammitt L, Hennessy T, et al. The Alaska *Haemophilus influenzae* Type b experience: lessons in controlling a vaccine-preventable disease. *Pediatrics*. 2006;118;421-429

CDC Tribal Awardees, FY 2006
(Tribal governments [TG], tribal organizations [TO], tribal health boards/coalitions [HB], Alaska Native health corporations [ANC], urban Indian health centers [UC], tribal colleges and universities [TCU])

1. ABERDEEN AREA TRIBAL CHAIRMEN'S HLTH. BOARD [HB]
2. ALASKA NATIVE TRIBAL HEALTH CONSORTIUM (3 awards) [ANC]
3. ALBUQUERQUE AREA INDIAN HLTH BOARD, INC. [HB]
4. ARTIC SLOPE NATIVE ASSOCIATION [ANC]
5. ASSOCIATION OF AMERICAN INDIAN PHYSICIAN (2 AWARDS) [TO]
6. BLACK HILLS CENTER FOR AMERICAN INDIAN HEALTH [TO]
7. CALIFORNIA RUAL INDIAN HEALTH BOARD (2 awards) [HB]
8. CHEROKEE NATION (4 awards) [TG]
9. CHEYENNE RIVER SIOUX TRIBE [TG]
10. CHOCTAW NATION OF OKLAHOMA [TG] (2 awards)
11. CHUGACHMIUT [ANC]
12. EASTERN BAND OF CHEROKEE INDIANS [TG]
13. FOND DU LAC RESERVATION [TG]
14. HO-CHUNK NATION [TG] (2 awards)
15. HOPI TRIBE [TG] (2 awards)
16. INDIAN HEALTHCARE RESOURCE CENTER TULSA [UC]
17. INDIGENOUS PEOPLES TASK FORCE (2 awards) [UC]
18. INTER TRIBAL COUNCIL OF ARIZONA, INC. [HB]
19. INTER-TRIBAL COUNCIL OF MICHIGAN [HB]
20. KAW NATION OF OKLAHOMA [TG]
21. KICKAPOO TRIBE (TX) [TG]
22. LUMMI INDIAN BUSINESS COUNCIL [TG]
23. MISSISSIPPI BAND OF CHOCTAW INDIANS [TG]
24. MUSCOGEE (CREEK) NATION [TG]
25. NARA OF THE NORTHWEST, INC. (2 awards) [UC]
26. NATIONAL INDIAN COUNCIL ON AGING, INC [TO]
27. NATIONAL INDIAN HEALTH BOARD [HB]
28. NATIONAL INDIAN JUSTICE CENTER [TO]
29. NATIONAL INDIAN WOMENS HLTH RESOURCE CTR [TO]
30. NATIONAL INDIAN YOUTH LEADERSHIP DEVELOPMENT [TO]
31. NATIONAL NATIVE AMERICAN AIDS PREV CENTER [TO]
32. NATIONAL NATIVE AMERICAN EMA ASSOC. [TO]
33. NATIVE AMERICAN COMMUNITY HEALTH CENTER [UC]
34. NATIVE AMERICAN HEALTH CENTER [UC]
35. NAVAJO NATION (2 awards) [TG]
36. NORTHWEST PORTLAND AREA IND. HLTH BOARD (4 awards) [HB]
37. POARCH BAND OF CREEK INDIANS [TG]
38. SALISH-KOOTNAI TRIBAL COLLEGE [TCU]
39. SAN CARLOS APACHE TRIBE [TG]
40. SANTEE SIOUX (NEBRASKA) [TG]
41. SOUTH PUGET INTERTRIBAL PLANNING AGENCY [HB] (2 awards)
42. SOUTHCENTRAL FOUNDATION (2 awards) [ANC]
43. SOUTHEAST ALASKA REGIONAL HEALTH CONSORT (2 awards) [ANC]
44. SOUTHERN UTE INDIAN TRIBE [TG]
45. STOCKBRIDGE-MUNSEE COMMUNITY [TG]
46. TOHONO O'ODHAM NATION [TG]
47. UNITED AMERICAN INDIAN INVOLVEMENT, INC. [UC]
48. UNITED SOUTH AND EASTERN TRIBES, INC. [HB]

49. WHITE MOUNTAIN APACHE TRIBE [TG]
50. YUKON-KUSKOKWIM HEALTH CORPORATION [ANC]

- Total number of awards: 69 awards to 50 awardees
- Geographic distribution = 19 states plus D.C.
  (Arkansas, Alaska, Arizona, California, Colorado, Michigan, Minnesota, Mississippi, Montana, North Carolina, New England, New Mexico, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Washington, Wisconsin and the District of Columbia)

Awardee categories:
- Tribal governments, N= 20
- Tribal organizations, N= 8
- Tribal health boards/coalitions, N= 9
- Alaska Native health corporations, N= 6
- Urban Indian health centers, N= 6
- Tribal colleges/universities, N= 1

Centers for Medicaid and Medicare Services (CMS)

Positive outcomes at the Centers for Medicaid and Medicare Services **(**CMS) include the establishment of an Office of Tribal Affairs under the Office of External Affairs with reporting requirements/dotted line to the Office of the CMS Administrator. Staff has increased to 5 FTE.

Health Resources and Services Administration (HRSA)

HRSA continues to actively work to ensure that AI/ANs have access to health care services and resources. The following are a few accomplishments for FY 2006:

Priority: Health Promotion and Disease Prevention
Expected Outcomes: To provide culturally competent comprehensive primary care to AI/ANs in HRSA-funded community health centers nationwide. Thereby, increasing access to primary care and enabling services or conveying health promotion and disease prevention messages to increase users, improve health outcomes, and initiate funding for New Access Points, Service Expansions, and Expanded Medical Capacity for AI/ANs nationwide.
Outcomes: FY 2006 President's Initiative funding for New Access Points, Service Expansion Initiative, and Expanded Medical Capacity serving AI/ANs (tribal entities) was over $1.7 million dollars. In FY 2006, the level of funding to health centers that are currently serving at least 50 percent or more AI/ANs is $97,732,018 and they served 152,756 clients in over 825 health centers out of 952 nationwide. HRSA continues to strengthen the health outcomes of AI/AN populations through the Health Disparities Collaboratives.

Thirteen health center teams of tribal entities and Urban Indian grantees are participating in diabetes, cardiovascular, and depression collaborative. As a result of their participation, their health outcomes have improved and they are sustaining the improvements over time.

Division Name
Health Resources and Services Administration
Region Name
N/A
IGA/HHS
N/A
Other

Priority: Health Professions Recruitment
Expected Outcomes: To expand and increase opportunities for serving Native American populations.
Outcomes: HRSA/Bureau of Health Professions and IHS continue to collaborate. Sixty-one National Health Service Corps (NHSC) clinicians are currently serving in ITU sites, including twelve new placements in FY 2006.

In addition, IHS participated in two Recruitment Fairs during the 2006 NHSC Annual Scholar

Conference. Scholars demonstrated increased interest in employment opportunities with the IHS. Results of this IHS recruitment effort will not be fully realized until the end of the Site Selection Phase and the 2007 Placement Cycle when scholars choose their employment sites.

Division Name
Health Resources and Services Administration
Region Name
N/A
IGA/HHS
IHS
Other

Regulation:

None to report.

Policy:

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE's Office of Human Service Policy analysts reviewed and commented on a wide variety of policy documents related to AI/AN/NAs including legislation and testimony for HHS and other federal agencies, budget proposals, Reports to Congress, grant announcements, and press releases.

Centers for Medicaid and Medicare Services (CMS)

Region I:

1. Boston Regional Office (RO) wrote version of citizenship letter in light of DRA provisions and forwarded as State Agency Regional Bulletin in November, 2006.
2. Distributed information to federally recognized tribes on an ongoing basis throughout the calendar year.
3. Coordinated with other state and federal agencies, HRSA, OPHS, RD's office, MA-DPH, seeking to assist Tribes.
4. RO continues working on several long-term issues that have not yielded concrete outcomes as of this date.

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Division Name
Health Resources and Services Administration
Region Name
N/A
IGA/HHS
IHS
Other

National Institutes of Health (NIH)

National Institute of Child Health and Human Development (NICHD)

The NICHD has continued to support the first American Indian faculty member, who completed the NIH residency phase of the Extramural Associates Research Development Award (EARDA) program, and is now being funded by an EARDA grant to enhance the research capacity at his AI serving college.

Legislation:

Administration for Children and Families (ACF)

Children's Bureau (CB)

The Child and Family Services Improvement Act of 2006, signed September 28, 2006, amended title IV-B, subpart 2 of the Social Security Act to include Tribal consortia as eligible applicants for the funds set-aside for Tribes. The Tribal set-aside is increased to 3% under the mandatory and discretionary funds from 1% and 2% respectively.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE staff conducted analyses, developed Administration positions and alternative approaches to address issues involved in the reauthorization of the Indian Health Care Improvement Act, and provided technical assistance within the Administration and to Congressional staff (upon request) on various proposed statutory provisions.

Centers for Medicaid and Medicare Services (CMS)

Region I

Updated Wampanoag Tribe on provisions of MA Health Care Reform Law in May, 2006.

Budget:

Administration for Children and Families (ACF)

FY 2006: $399,108,975

Administration for Native Americans (ANA): $31,564,255
SEDS, Language, Environmental, Environmental Mitigation, and Healthy Marriage grants.

Children's Bureau (CB): $11,265,348
Formula Grants, FY 2006: Title IV-B, subpart 1: Child Welfare Services $6,033,348; Title IV-B, subpart 2: Promoting Safe and Stable Families $4,832,000; One Demonstration grant for Collaboration between TANF and Child Welfare to Improve Child Welfare Program Outcomes

(CFDA # 93.556) - up to $400,000 per year for five years.

Child Care Bureau (CCB): $99,581,618
Family and Youth Services Bureau (FYSB): $15,163,000
Family Violence and Prevention Formula Grants to Tribes: $12,563,000 (10% of total FVPS budget); FYSB set-aside for Tribes: Mentoring Children of Prisoners Program - $1,700,000 (5% of total funds); Runaway and Homeless Youth Programs - $900,000.

Office of Child Support Enforcement (OCSE): $30,000,000

Office of Community Services (OCS): $30,764,960
Division of Energy Assistance (DEA) Targeted Discretionary Funding: $26,131,432
Community Services Block Grant (CSBG) Targeted Discretionary Funding: $4,633,528

Office of Family Assistance (OFA): $177,174,400
Tribal TANF Block Grants (as of 10/1/06) - $168,137,216. (NOTE: There is no separate budget line item for the Tribal Family Assistance Grants (annual TANF grants). The funding for these grants is withdrawn from the State Family Assistance Grants and is included within the budget allocation for State TANF); Tribal TANF & Child Welfare Services Grants - $1,479,164; Native Employment Works Grants - $7,558,020.

Office of Head Start (OHS): $3,595,394

FY 2006	Total Dollar Amount	# of Grantees	Purpose
One Time Funding	$1,407,949	27	Facility Repairs, Playground Equipment, Correct Non-Compliances
Oral Health	$245,637	4	
Conference	$151,157	55	
Tribal Colleges	$1,790,651	12	

Agency for Healthcare and Research Quality (AHRQ)

FY2006 - $318,695,000
Targeted/Discretionary Funding, FY 2006: $3,618,247

Administration on Aging (AoA)

FY 2006: $1,369,028
Targeted/Discretionary Funding, FY 2006:$32.4 Million

Centers for Medicaid and Medicare Services (CMS)

FY 2006: $377,304

Central Office: $333,000
Region II: $3,000.00
Region IV: $3,000.00
Funds allocated for Travel - Consultation and CMS Day/Annual NAC meeting.
Region VI: $12,000.00
There are at least three (3) individuals who attend tribal meetings. This includes the NAC and the Medicare and Medicaid personnel.
Region VII: $4,304.46
Region VIII: $14,000
Region IX: $8,000

Indian Health Service (IHS)

Targeted/Discretionary Funding, FY 2006: $3,898,246

National Institutes of Health (NIH)

National Heart, Lung, and Blood Institute (NHLBI)

Targeted/Discretionary Funding, FY 2006: $100,000

An additional $50,000 was committed for implementation of Honoring the Gift of Heart Health local tribal community education

programs in partnership with the Indian Health Service (Cardiology Division)

The NHLBI provided funding ($50,000) for cardiovascular heart health training in the Oklahoma Service Area in February 2006.

Other Budget Matters:

Administration for Children and Families (ACF)

Child Care Bureau (CCB)

In FY 2006 the CCB continued to fund and support research projects relevant to tribal communities. This research (related to provider/parent education and support, child care payment rates, and cultural preservation) is helping to inform choices and decisions that Tribes must make when administering the child care subsidy program.

CCB convened a joint conference of State and Tribal Child Care and Development Fund (CCDF) grantees for the first time in more than ten years. This joint conference reinforced the *Good Start, Grow Smart (GSGS)* coordination goal by facilitating shared dialogue between States and Tribes around specific GSGS topics, including the development of early learning guidelines and professional development.

CCB hosted a Native Leadership Forum on Cultural Curricula and Indigenous Language Acquisition in Child Care. As a result of this Forum, Tribal CCDF grantees expanded their understanding of Native language and culture programs throughout the United States. In addition, grantees that participated in the Forum have independently pursued follow-up activities and ongoing communication opportunities with each other, creating their own informal learning community to promote improved school readiness for Native American children through the incorporation of Native language and culture in Tribal child care programs.

Office of Head Start (OHS)

Starting October 1, 2006, there is a new Division Director, Renee Perthuis, and the AI/AN Branch is on the same level as all of the Regions. A summary of the ACF Tribal Consultation as it pertains to Head Start is as follows:

Funding
Tribal Concerns:
- Additional Resources needed for costs for running program such as fuel, facilities and transportation.
- Increasing salaries to support teacher retention.
- Funding needed to support Federal mandates.
- Release of funds to the programs is very slow.

OHS Response:
- OHS absorbed 1% rescission funds allowing tribes to have flexibility in their budget decisions.
- Tribes need to implement a "staff retention" plan. Attached a list of Tribal Colleges and Universities.
- There are several Information Memorandums (IMs) that assist in addressing mandate requirements.
- OHS is working on an internal plan to support an efficient and timely partnership with grantees to achieve
  timely disbursement of funds.

Communication:
Tribal Concerns:
- Grantees are feeling like they are not being treated with respect.
- There needs to be more consultation with Tribal Leaders to facilitate communication with Tribes.
- Danya International requests information with very short notice to the Tribes.

OHS Response:
- The OHS will work with its staff to improve customer service. OHS respects all Tribal sovereignty.
- Quarterly conferences will be held with tribes via face-to-face, teleconferences, or update letters.
- OHS will work with Danya to set a timeline of not less than one week for all requests.

Monitoring/Review
Tribal Concerns:

- Not enough American Indian/Alaskan Native reviewers.
- Many of the National Reporting System questions are not appropriate for native children.
- Review teams are too large and disrupt classrooms.

OHS Response:

- There is an ongoing effort to recruit reviewers who are AI/AN. Professionals need to be encouraged to apply.
- It is not possible to create a national assessment that is familiar to all of the children. OHS feels this tool is fair.
- OHS is working on the size of the monitoring review teams so they are proportional to the program size.

Assistant Secretary for Resources and Technology (ASPE)

In March and May, 2006, ASRT and IGA convened Department-wide budget formulation and consultation meetings to incorporate Tribal priorities in the development of the HHS FY07 budget request. In February 2006, the Administration submitted an IHS budget to Congress that included an increase of $1.2 billion to address the health priorities highlighted by Tribal leaders during these budget consultation meetings.

Food and Drug Administration (FDA)

FDA does not formulate its budget by population or ethnic group. FDA's grant programs for which Tribes qualify are competitive for various other stakeholders and are funded with discretionary resources; therefore awards to Tribes cannot be predicted. In FY 2006, an estimated $23 million was available for competitive research awards. No awards were made to Tribes.

FDA continued to work with the Bureau of Indian Affairs, U.S. Department of the Interior, the Environmental Protection Agency, and the Department of Justice to provide a web-based version of the pilot environmental health workshop for Tribes through tribal colleges and Universities--Southwestern Indian Polytechnic Institute, Little Big Horn College, United Tribes Technical College and Cankdeska Cikana Community College. The workshop provides training for Tribes to increase tribal knowledge about environmental safety.

FDA continued to work with the Hoopa Valley Tribe to provide orientation to the Agency's Model Food Code and regulatory technical assistance in low-acid canning processing certification.

Pacific Region Retail Food Specialist continued to work with the Crow Reservation, Montana, in the Voluntary National Retail Program. The specialists provided food safety management courses, information on the Food Code. Regional Shellfish Specialists provided training and technical support to Tribes in western Washington on shellfish harvesting and handling practices.

The New England District Public Affairs office has maintained contact with several of the Native American Tribes within the District with the intent to schedule more tribal briefings. The PAS has updated its mailing list and is putting together an informational packet to mail to tribal health directors.

New York District Public Affairs Office joined efforts with organizations serving Native American communities in March 2006 Nutrition Month. The public affairs specialist (PAS) contacted the Shinnecock Nations in Long Island and developed curriculum to conduct presentations at the reservations. The PAS presented “Healthy Eating Habits” at East End Centers. Native Americans are suffering from a high incidence of diabetes.

Northeast Region Retail Food Specialists continued to work with the Mohegan Tribal Health Department in Connecticut in the Voluntary National Retail Program Standards. The NER is helping the Tribe with a self-assessment program. Food Specialists continue to work with the tribe in the standardization of their staff in the application of the Model Food Code. Food Specialists continue to provide

technical assistance and training when requested by the Mashantucket Pequot Tribe.

In April 2006 a representative from the FDA Minneapolis District, Green Bay Resident post, attended a 2 day Region V Tribal Council meeting held at the Oneida Radisson, Green Bay, WI. This individual interacted with the various registrants attending and provided written FDA public affairs information to many of the participants.

10/19/2006 the Chicago District Public Affairs provided food safety, ALERT and Fight Back materials for the Oglala Sioux Tribe. A USPHS Officer will be providing training to Head Start Educators at the Pine Ridge Hospital in Pine Ridge SD.

National Institutes of Health (NIH)

National Heart, Lung, and Blood Institute (NHLBI)

In FY2005, NHLBI provided $200,000 to IHS to fund 5 Regional Training Cardiovascular Health (CVH) Training Workshops for tribal communities across the U.S.
Resulting from tribal consultations and the NIH peer review process, the NHLBI awarded 4 additional grants in response to the Request for Applications entitled, "Community-responsive interventions to reduce cardiovascular risk in American Indian and Alaska Natives." FY2006 support - $2.083 Million

Substance Abuse and Mental Health Services Administration (SAMHSA)

Suicide Prevention Efforts

In 2005 SAMHSA awarded a SAMHSA Emergency Response Grant (SERG) to the Standing Rock Sioux Tribe due to an outbreak of suicide clusters on their reservation. SERG funding is designed to meet emergency substance abuse and mental health needs for primary victims and their families in local communities which are a direct consequence of a precipitating event when there are no other Federal or State resources available.

SAMHSA staff and the One Sky Center staff worked closely with the Tribe to design and implement a suicide prevention program at Standing Rock, the Oniyapi Program. Based on SAMHSA's recommendation, the tribal chairman and council mandated to the tribal Addiction and Dependency (A&D) Program Director that the program must be A&D certified by the State of North Dakota. A Bismarck-based consultant from SAMHSA's Disaster Technical Assistance Center (DTAC) has been working closely with Tribe and the state in preparing for this licensure application and review process. The SAMHSA project officer visited the Tribe in August to insure these grant activities were in place and to coordinate with the new IHS psychologist assigned to Standing Rock.

There were no completions during the last 3% months of FY 2006 during which time the Oniyapi program was fully implemented and the case managers have full caseloads providing case management services and arranging treatment and ancillary services for at-risk clients. The Tribe has received two additional behavioral health staff positions from the Tribe to assist with the Oniyapi program. The strategic suicide prevention plan that was developed and implemented at Standing Rock is being considered as a model by other Indian reservations and the Indian Health Service.

Although the SERG grant funding ends in December 2006, The Standing Rock Sioux Tribe was competitively awarded a Youth Suicide Prevention and Early Intervention Program grant in October 2006, This grant will bring together tribal leaders, service providers, youth and faith community leaders to implement a comprehensive tribal youth suicide prevention and early intervention plan that will identify and increase youth referral to mental health services and programs, increase protective factors and reduce risk factors for youth suicide, and improve access to prevention and early intervention services. SAMHSA staff are coordinating the transition between the two

grants to insure that critical suicide prevention services are provided to the Standing Rock reservation.

Methamphetamine Abuse

In FY 2006 SAMHSA began an important collaboration with HHS' Office of Minority Health and National Institutes of Health to address the outreach and education needs of Native American communities on methamphetamine (meth) abuse. Through this initiative several Native American organizations are developing a national information and outreach campaign and a culturally specific methamphetamine abuse education kit. In addition, they are documenting and evaluating promising practices in education on meth use, and creating meth awareness multi-disciplinary education teams. This project brings federal, tribal, state, and local resources together to reach families in urban and rural Native American communities where methamphetamine abuse become a major threat to healthy living and lifestyles in those communities.

Through SAMHSA grant funds and SAMHSA's participation in the HHS Tribal Methamphetamine Initiative it is expected that Tribes will continue to develop and implement culturally-relevant suicide prevention and substance abuse strategies that have replication potential so that they may be shared with or adapted to other tribal communities. Furthermore, by traveling to Indian County and meeting directly with tribal leaders of the HHS Tribal Methamphetamine Initiative sites selected for prevention intervention, treatment and recovery efforts, SAMSHA and HHS Leadership have garnered critical buy-in from tribal leadership that should lead to the successful implementation of this initiative at these five tribal sites.

Increased Access to SAMHSA Grants/Increased Funding to Tribes

Beginning in FY 2005, Tribal entities became eligible for all SAMHSA grants for which States are eligible unless there is a compelling reason to the contrary. In furtherance of this policy change, in FY 2006 SAMHSA initiated several proactive efforts to facilitate the grant application process for Tribes and tribal organizations, which should result in more competitive grant applications from and an increased number of grant awards to Tribes and tribal organizations in FY 2007 and beyond. As an example, because Tribes and tribal organizations were able to compete for Strategic Prevention Framework State Incentive Grants (SPF-SIG) for the first time in FY 2006, SAMHSA conducted special outreach efforts to assist them in applying for this grant. As a result of this special outreach effort, 16 tribal entities applied and 5 were funded for a total of $5,520,755. The tribal applicants did an outstanding job of including culturally appropriate services in their substance abuse prevention strategies.

In addition, in conjunction with DHHS's Barrier's Access Study report, SAMHSA's Acting Deputy Administrator convened a group of tribal representatives to review agency Requests for Applications (RFAs) from a tribal perspective. This group provided some very insightful comments and some changes have already been incorporated into FY 2007 funding announcements. Other changes may be included in future SAMHSA RFAs.

Increased Access to SAMHSA

In FY 2006 SAMHSA used the revised DHHS Tribal Consultation Policy (TCP) as a starting point for revising the SAMHSA policy and began this process by soliciting comments on the existing SAMHSA TCP at each of the DHHS Regional Tribal Consultation sessions. During FY 2006 a Technical Team workgroup consisting of tribal representatives and federal staff developed a second draft SAMHSA TCP that was sent out in a Dear Tribal Leader letter to Tribes for review during a 90-day comment period (ending on December31, 2006). SAMHSA expects to have a signed policy in place in February 2007.

The goal of the revised SAMHSA Tribal Consultation Policy (TCP) is to assure meaningful involvement of Indian Tribes in

decision-making on SAMHSA policies that have tribal implications related to substance abuse and mental health services. The implementation of the revised TCP is a critical component of SAMHSA's commitment to fulfill its role in assuring that tribal communities are safe and healthy.

REGION OUTCOMES AND ACCOMPLISHMENTS

Region II

Priority: Pandemic Flu Tribal Community Plan.

Expected Outcomes: Pandemic influenza planning is a monumental task with many different factors to consider and it is important that all Tribes collaborate to ensure the most effective and appropriate coordinated response. It is expected that state and local planning will be augmented.

Outcomes:

Division Name
Office of Regional Director, Office of Public Health and Science (OPHS), Office of Public Health Emergency Preparedness (OPHEP), Centers for Disease Control and Prevention

Region Name
Region II

IGA/HHS
IGA will document meetings and follow up as necessary.

Priority: That Federal department will foster a close working relationship with the Tribes in Region II.

Expected Outcomes: It is expected that by communicating directly with the Tribe, there will be opportunity to work in partnership with tribal governments on a government-to-government basis. HHS will promote an open dialogue and will provide assistance to the Tribes through the sharing of information, technical assistance and accessibility to HHS programs and funding.

Outcomes:

Division Name
U.S. Department of Health and Human Services
Office of Regional Director
Office of Intergovernmental Affairs
Office of Public Health and Science
Centers for Medicare & Medicaid
Administration for Children and Families
Administration on Aging

Region Name
Region II

IGA/HHS
IGA will document meetings and follow up as necessary.

Region V
ORD, ACF, ORHA, OPA, SAMSHA, CMS

Follow-up was conducted on issues raised, including policy information and extensive technical assistance, particularly on bioterrorism funding concerns, child welfare, and Medicare/Medicaid issues. Bemidji-area representation at national consultation and conferences increased significantly, giving them a greater voice in policy/decision making.

Follow-up on Red Lake's children's mental health concerns was also noteworthy, with ORHA funding mental health/social services support, as well as SAMSHA and ACF providing technical assistance, as facilitated by the RD. Results included: exploration of utilizing Medicaid/third party mental health services billing; coordinating funding streams, behavioral health capacity building, possible National Child Traumatic Stress Network t/a and grants; and NICWA follow-up t/a. On 11/02/06, Red Lake and area tribes conducted a conference, "Partnership to Address the Mental Health Needs of Native Youth" Conference in Bemidji, MN, funded in part by the RD, with SAMHSA and IHS participation.

Regulation:

Region V
ORD, ACF, ORHA, OPA, SAMSHA, CMS

Medicare-like rates (resolved). CAHs receive interim rates based on their costs while other hospitals will receive interim rates based on DRGs. Proposed Rule on Medicare-like Rates (Section 506) published in the Federal Register.

Reviewed Region V States' Annual Progress and Services Reports and Program Improvement Plans for progress towards improved ICWA compliance and consultation with the Tribes.

The Region reviewed all submitted Tribal Child Care plans and amendments. If revisions were necessary for compliance, assistance was provided to the Tribes to accomplish these revisions. One construction application was also reviewed and assistance provided to the Tribe on necessary revisions.

TANF staff approved five Tribal TANF plans and one Native Employment Works (NEW) plan during the fiscal year.

TANF staff provided technical assistance to Tribal TANF programs that had received penalty letters regarding failure to meet work participation rates and assisted a Tribal TANF program in adjusting its budget to undertake the needed renovation of a facility to provide better customer service.

Policy:

Region IV
ACF

In 2006, as a result of ACF Region IV multi-year effort to promote the availability of Good Start, Grow Smart early learning resources for children enrolled in Tribal CCDF programs, Tribal and State partners reported increased Tribal participation in State GSGS activities:1) In Alabama, the Poarch Band of Creek Indians is now represented on the State's Early Learning Guidelines Committee, its Professional Development Committee, and its Child Care Advisory Committee, 2) In Mississippi, the Mississippi Band of Choctaw Indians is now represented on the State's immunization Committee, participates in its Credentials Director's Training, and has access to the State Early Learning Video Library, 3) In North Carolina, the Eastern Band of Cherokee Indians is now working with the State on Infant-Toddler Early Learning Guidelines and the Tribal CC Administrator chaired the State's Region A Partnership, which administers the Smart Start school readiness initiative, and 4) in South Carolina, the Catawba Indian Nation is now represented on the State's Child Care Coordinating Council and Early Learning Guidelines Committee, and accesses the TEACH professional development program. These examples of Tribal-State cooperation will provide Tribal child care programs with the knowledge and experience needed to assess how and whether to incorporate GSGS elements into their CCDF programs and perhaps lay the foundation for effective Tribal-State cooperation in other areas.

Region V
ORD, ACF, ORHA, OPA, SAMSHA, CMS

Medicaid Administrative Match (resolved). On June 9, 2006, CMS and IHS jointly released a second State Medicaid Directors (SMD) letter concerning MAM. This letter clarifies policy regarding the source of funds for certified expenditures of Tribes and tribal organizations that operate with 638 funding. MI Tribes notified that states can contract with tribes to perform administrative functions, and bring the proposal to CMS. Or the tribes may bring a proposal to the state or request technical assistance from CMS. [CMS spoke with the MN State Tribal Liaison, who contacted the MI State Liaison to provide MAM technical assistance.]

Demonstrated support of the development of State-Tribal IV-E agreements to all Region V States and Tribes, including a site visit by ACF staff to MN to learn about their Indian Child Welfare project; researched and shared materials with appropriate Region V States on such agreements.

The CDC Coordinating Office on Terrorism Preparedness and Emergency Response (COTPER) Liaison convened a conference call on June 5, 2006, with the MI State Project Officer and the Program Coordinator for Michigan, Bioterrorism/Emergency Preparedness for the GLITC, to discuss tribal emergency preparedness for tribal nations in MI, and engage tribal representatives as appropriate. The Project Coordinator stated although communication and collaboration between the tribal nations and the state is still somewhat of an issue, there has been and continues to be ongoing improvement in this initiative. She stated that 4 out of the 9 tribes served have tribal response plans and that all MI tribes have an all-hazards plan in place. She mentioned that the role of tribal involvement in the cooperative agreement plan (objectives) needs further discussion and that she does feel both MI and the tribes need to continue working together to allow this to happen.

She recommended that state of MI clearly articulate to the tribes what their role is in planning initiatives and that the tribes clearly articulate to the state what their parameters are in meeting certain deadlines i.e.; understanding tribal clearance process etc. All three players are committed to strengthening relationships and are available as resources for the tribes to contact with more specifics.

Title X grants are discretionary and categorical. IHS acceptance of Title X grant funds would constitute an impermissible augmentation of the IHS appropriation. Title X funds can be accessed through open competition. Non IHS clinics and through state Title X grantees. The Michigan Dept. of Community Health Request for Assistance (RFA) included tribal communities who are eligible for the Title X funds. OPA promoted tribal funding to eligible tribal grantees.

Region VI

State of Texas was contacted by ORD in response to issue raised by Alabama-Coushatta not being invited to Pandemic Flu Summit. They assured that tribal representatives would be invited to future such meetings.

The Pueblo of Acoma and the Muscogee (Creek) Nation filed a formal "Letter of Intent" with ACF to develop and implement a Tribal TANF program. ACF Region VI Tribal TANF staff met with elected and senior tribal officials and provided technical assistance throughout the year.

Region VII

CMS: Part D outreach and education to Indian Country included technical assistance to Tribes regarding complex Medicaid and Medicare issues, meetings with Tribal Councils and Health Directors to identify needs, address issues and explore ways to provide and coordinate assistance, established a list serve as another way to communicate, onsite and financial participation to Tribal sponsored health fairs and conferences, and conference calls and meetings with the CMS Tribal Technical Advisory Group to address issues/concerns regarding Medicare, Medicaid and the State Children's Health Insurance program and their impact in Indian Country.
Emergency Preparedness: The Medical Reserve Corps in OPHS is available to the Tribes. Through the Emergency Preparedness Regional Coordinator the tribes have access to training opportunities and informational resources in the region.

SAMHSA: Grants are available to the Tribes to address problems and to be a source of funding. Tribes can apply for the same SAMHSA grants as States.

OPHS: Power of Choice training for native youth on making good nutritional choices. Three tribes participated. An Intertribal Diabetes Conference was held. A Conference for Prevention of Overweight and Obesity was held with an emphasis on minority and American Indian health with tribal representation. Native American Symposium (co-sponsored by OPHS) addressed the health and social concerns of both the urban and reservation American Indian was held Fall 2005.

Region X
Seattle, including AoA, CMS, and HRSA.

Tribes requested access to TTAG 5 Year Strategic Plan and Website access was provided. The Plan was presented to Dr. McClellan at the February 2006 TTAG meeting. He and senior staff have been briefed on the plan's objectives and strategies with recommendations to improve AI/AN health disparities and a 5 Year Budget estimate. Favorable response received with compliments of working directly with the tribes and states. The Tribes asked CMS, when developing new legislation, or new rules and policy changes, to consult with the Tribes first. The Tribes and TTAG delegates can assist CMS with recommendations to enhance implementation in Indian country and avoid pitfalls that can be circumvented.

Equitable Relief: The TTAG requested the opportunity to review a CMS Decision Memorandum to IHS regarding a decision to waive the Medicare Part B premium surcharge for members of tribes that were served under Interagency Agreements between CMS and IHS from the time period July 1999 to 2002. While the TTAG support this decision to waive the late enrollment fee they believe it did not go far enough since it only applies to 62 tribes nationwide. The TTAG argues that it should not matter whether there were Interagency Agreements or not since in most instances the IHS was the only federal agency available for AI/AN beneficiaries when making enrollment decisions about Part B. The TTAG recently sent a letter to Dr. McClellan appealing this decision.

Medicaid Administrative Match (MAM): A general overview was provided describing the intent and guidelines for operation of this program. The tribes raised concerns about the workload reporting requirements that go into documenting their work through time-studies which are cumbersome and complicated and sometimes not worth the effort. Region X indicated they are working in consultation with Washington State and Tribes in to resolve some of these issues. During FY 2005 HHS Tribal Consultation sessions Tribes requested Policy Guidelines to operate this program. On October 18, 2005 CMS released a Dear State Medicaid Director (SMD) Letter containing guidance for participation by arrangements that use certified public expenditures by a "unit of government" to fulfill the non-federal matching requirements for administrative activities under the Medicaid program. The letter contained the following footnote:

> "Federal funds may not be used to meet State matching requirements, except as authorized be Federal law. Although Federal HHS funds awarded under ISDEEA may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources."

Although the footnote correctly states the applicable principles of law, after further review, the TTAG subcommittee on this topic have determined that the conclusion in the last sentence would not apply when the full financial benefit and responsibility has been assigned to the Tribal organizations. IHS and CMS are issuing a joint SMD letter to clarify this footnote.

The Tribes raised concerns with the alternate benefit package and they were advised that the law does provide some opportunities and flexibilities to work with States in carving out something agreeable to Tribes.

Tribes were concerned with Medicaid Reform. It was the Tribes understanding that States were informed about the requirement to consult with Tribes before waiver amendments could be approved by CMS. What will be the impact to AI/AN people with new waivers, such as State of Idaho, that when implemented will require co-pays. CMS agreed to bring back east the significance of co-pay charges to AI/AN people.

CMS letters to Tribal Leaders were distributed May 3, 2006 identifying Native American Contacts (NACs) as their primary point of

contact in each respective Region. General Guidelines were described for resolving both Plan and Beneficiary problems and issues. If these procedures did not resolve the problem, the NACs were available to triage the issue within their respective Regional Office staff to facilitate timely resolution. Tribes were appreciative of these efforts. TTAG Outreach and Education Subcommittee was recognized for all their support and guidance to help CMS communicate with Tribes and their communities.

The Tribes asked that CMS, when developing new legislation or new regulations, determine what are the specific AI/AN issues that need to be addressed before the law is enacted or before the regulations are developed so that the Tribes do not have any unintended consequences. An example presented was the issue of identification and the concerns of how costly and problematic this will be. For instance obtaining a birth certificate may not be a problem if a birth certificate was issued in the right place such as a hospital etc. which in many tribal communities is not always the case. Another problem is that you cannot send away for a state-issued ID because you have to be there in person in order to have the ID card issued. Some persons live in remote villages and require them to fly to the nearest Division of Motor Vehicles which issues the ID cards. Such a trip can be very costly to the family. CMS will take this issue back to CO for them to re-look at the issue and the impact this will have on AI/AN.

IHS Urban Clinic Budget:

· *Tribal Leader Perspective:* The President has "lined-out" the budget within IHS for the urban clinics. One solution would be for HRSA to transfer the $32 million dollars from its budget to IHS, rather than rely on Community Health Centers as the "access to care" replacement for Indian care in urban areas. There is concern how Community Health Centers will absorb those additional patients without further funding to support the cost of patient care. The government is obligated by treaty to provide care to Indian Tribal members, including within urban communities.

· *HRSA Liaison Note:* The HRSA prepared response was read to the audience. The HRSA response included acknowledgement of the Tribe's concern and that dialogue between HRSA, IHS, and Tribal Leaders was important if indeed the budget was approved as presented.

· *Final Tribal Recommendation:* maintain urban clinic funding through IHS appropriations.

HRSA and IHS Overlap:

· *Tribal Leader Perspective:* The Bureau of Primary Health Care now has 21 Tribal-run programs. There is unnecessary and inefficient overlap in the health service profession. There should be efforts made by HRSA and IHS to reduce the amount of administrative duplication required for dual-funded programs.

· *HRSA Liaison Note:* It is assumed the referral was to "Community Health Centers."· *Final Tribal Recommendation:* a workgroup should look at various administrative duplication issues as they are identified and change policy to eliminate waste of administrative effort.

FTCA – Federal Tort Claims Act:

· *Tribal Leader Perspective:* Dual-funded programs find the BPHC deeming application process burdensome to gain FTCA malpractice coverage through BPHC. The requirement to gain deemed status through 2 funding agencies is burdensome and confusing.

· *Final Tribal Recommendation:* The IHS FTCA coverage should be extended to the Tribe's 330 program status and cover non-Indian care through their existing IHS FTCA deemed status.

Pharmacy 340B:

· *Tribal Leader Perspective:* The 340B pharmacy program is a prime vendor opportunity for Tribes, even if they are not in a 330 program.

· *Final Tribal Recommendation:* Tribes should have access to the 340B program regardless of BPHC/CHC 330 status.

Pharmacy 340B:

· *Tribal Leader Perspective:* There are numerous administrative and burdensome formulary maintenance rules between the

IHS/VA pharmacy and the HRSA 330B pharmacy programs. The need for multiple formularies within the same service center is inefficient.

· *Final Tribal Recommendation:* HRSA and IHS should work to reduce the administrative burden of administering both pharmacy vendor programs and also work to increase efficiencies.

BPHC Collaborative Program:

· *Tribal Leader Perspective:* Tribes are concerned about the mandated involvement in a collaborative as a 330 program. IHS has several well-designed chronic-disease focused programs, such as diabetes. Dual-funded programs are not allowed to default to the IHS health focus topics that are less cumbersome. The involvement of Tribal programs (with access to IHS clinical program and service support) in BPHC collaborative program is time-consuming and often requires double entry of data.

· *Final Tribal Recommendation:* HRSA should acknowledge a Tribe's effort in community population level health activities and allow for exemptions from the BPHC collaborative mandate.

Data Entry and Reporting Requirements - Collaboratives:

· *Tribal Leader Perspective:* The mandated collaborative involvement and UDS reporting both often result in the need to enter data into separate electronic data systems. The Tribes often have software (RPMS) that is used for patient clinical information. It is recommended that Tribes be allowed to use their own programs, rather than "PECS" in order to avoid duplication of data entry and reporting.

· *Final Tribal Recommendation:* HRSA and IHS should reduce burdensome and often separate expectations around common service delivery efforts and its related data entry and reporting requirements.

Data Entry and Reporting Requirements – UDS Reporting:

· *Tribal Leader Perspective:* The effort to generate the data and information for the UDS report is time consuming and often involves duplication of reporting effort, and/or a recalculation of all information due to differing reporting time periods (between IHS and HRSA).

· *Final Tribal Recommendation:* HRSA should provide Tribes with technical assistance, training, and support to meet the UDS reporting requirements and also to ensure the RPMS system is fully capable to generate the data for the UDS report. It is a request of Tribes that a Tribal-specific UDS report training be held to provide technical assistance on reporting and to meet the goal of avoiding duplication of data reporting (to two separate agencies about the same services provided). Both IHS and HRSA Information Systems representatives should collaborate on the development of a streamlined process and training for required reporting by Tribes to both agencies.

HRSA/IHS Workgroups:

· *Tribal Leader Perspective:* There is a concern that the agencies may be working on Tribal issues without proper representation and input from the Tribes.

· *Final Tribal Recommendation:* Official workgroups at the agency level should include Tribal representation.

HRSA Goals:

· *Tribal Leader Perspective:* A comment was made that "if you have excellence in management, this can support the rest of the goals more effectively."

· *Final Tribal Recommendation:* HRSA should consider moving the HRSA Goal 7: "Achieve Excellence in Management Practices" as the HRSA Goal 1.

HRSA – The Agency:

· *Tribal Leader Recommendation:* It is recommended that HRSA move from a position of "Why something can't be done, or can't happen" to a position of "How something can be done or can happen."

Vaccination Compensation Program:

· *Tribal Leader Perspective:* There was a question as to the reasoning behind such a program. Questions included: "Why is the program there in the first place?", "Is it about

liability?", "Many vaccines are successful, is it related to the statistically small chance of a poor outcome?", "Is it related to the pandemic possibility?"
HRSA Answer:
· *Tribal Leader Recommendation:* The HRSA Liaison should send program information about the vaccination compensation program to the Alaska Native and the NW Portland Area Indian Health Board offices so they could post the information on their web site for their constituents to access (completed 5/3/2006 – Web links and phone number from the Official HRSA site were provided).

Region X of the U.S. Administration on Aging oversees 68 direct federal-tribal grants, under Title VI of the Older Americans Act for nutrition and home and community based services, such as congregate and home delivered meals, transportation, homemaker and respite for caregivers. There were four new applicants for the last three-year grant cycle but they cannot be funded unless Congress increases appropriations. Two state/tribally developed conferences have been held -- Washington state's was on kinship care, such as grandparents raising grandchildren, and Oregon's conference was for Native American caregivers. The Region X AoA office continued to give technical assistance to Title VI grantees on a daily basis and make technical assistance visits to a limited number of tribes each year.

The following is the response that SAMHSA issued to address issues raised at the Spring 2006 Tribal Consultation Sessions.

SAMHSA Consolidated Response to Tribes on Issues Raised at Regional Tribal Consultation Sessions, Spring 2006

The following list of Substance Abuse and Mental Health Services Administration (SAMHSA) resources, grants information, and technical assistance has been compiled to address four major issues that were frequently raised by Tribal leaders and representatives during the spring 2006 HHS Regional Tribal Consultation sessions. SAMHSA is providing this information to the Tribes and HHS Regional Offices in order to respond to concerns and questions posed regarding methamphetamine abuse, suicide prevention, child welfare, and access for Tribes to SAMHSA grants. SAMHSA staff participated in the following Consultation sessions: Region I, II, III, IV combined (Nashville Area); Region V (Bemidji Area); Region VI (Albuquerque Area, Navajo Area, Oklahoma Area); Region VII (Aberdeen Area, Oklahoma Area); Region VIII (Aberdeen Area, Billings Area, Navajo Area); Region IX (California Area, Navajo Area, Phoenix Area, Tucson Area); and Region X (Alaska Area, Portland Area).

METHAMPHETAMINE ABUSE

SAMHSA included $25 million in the President's budget request for fiscal year (FY) 2007 for a new voucher program, modeled on the current Access to Recovery (ATR) initiative, for methamphetamine abuse prevention and treatment. Grants will target areas with high methamphetamine use prevalence to support treatment and recovery support services.

Methamphetamine abuse treatment and prevention resources include:

- Matrix Model Outpatient Treatment Client Manual Culturally-Adapted for American Indians/Alaska Natives for use with Matrix Model of Intensive Outpatient Treatment for People with Stimulant Use Disorders. The components of the Model are Cognitive Behavioral Therapy, Motivational Interviewing, Family Therapy and Contingency Management. Ordering Information: 1- (800) 310-3140

- Arizona Methamphetamine Treatment Centers of Excellence Program Manual. The Manual is a focused approach for implementing evidence-based practices in the treatment of clients with methamphetamine use disorders. The Centers are a set of interwoven best practices and technologies with demonstrated efficacy in improving

client retention in treatment, instilling necessary skill competence and social support to overcome cravings to use methamphetamine and providing the foundation for long-term substance abstinence and recovery. The Centers are grounded in Arizona's individualized, strengths-based assessment and service planning approach and use specific, targeted strategies to capitalize on these elements in the delivery of treatment services. For additional information email: cabhp@email.asu.edu.

- ATTC's Methamphetamine 101, *Etiology and Physiology of an Epidemic Digital Training Module* and 102, *Introduction to Evidence-Based Treatments Digital Training Module*
  - *Methamphetamine 101*. This video created by the Addiction Technology Transfer Center (ATTC) provides information about the etiology and physiology of an epidemic. This video is designed to provide an overview of the medical, psychological, and societal effects of methamphetamine abuse and dependence, and is intended to be used in conjunction with the second module addressing methamphetamine treatment. http://www.abhp.arizona.edu/Training/Store/index.aspx#Meth101
  - *Methamphetamine 102*. This second video by the ATTC provides information about evidence-based treatment and addresses foundations for a clinical approach to methamphetamine treatment with emphasis on the Matrix Model, an evidence-based treatment protocol that has withstood the rigors of clinical trial research. http://www.abhp.arizona.edu/Training/Store/index.aspx#Meth102

- The Methamphetamine Treatment Project (MTP) is a multi-site initiative funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) to study the treatment of methamphetamine dependence. Jointly implemented by the University of California Los Angeles Integrated Substance Abuse Programs (ISAP), and the Matrix Institute on Addictions, its goal is to generate knowledge regarding how the Matrix comprehensive treatment protocol can be effectively transferred to the community drug treatment system. The website (http://www.methamphetamine.org) provides information about the project, results when they become available, as well as general information on methamphetamine abuse and treatment and links to other useful sites. In addition, the April-June 2000 issue of the *Journal of Psychoactive Drugs* describes the efforts and progress of the MTP and includes more than a dozen articles on various aspects of the project.

- *Treatment for Stimulant Use Disorders: Treatment Improvement Protocol (TIP) Series 33* is available from the National Clearinghouse for Alcohol and Drug Information (NCADI) at http://www.ncadi.samhsa.gov (or call 1-800-729-6686). Treatment Improvement Protocols are best practice guidelines for the treatment of substance use disorders, provided as a service of CSAT. CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs. Tip 33 is applicable to methamphetamine abuse.

- Booklet, video and PowerPoint entitled *Meth: What's Cooking in Your Neighborhood*, available from NCADI. Useful information on what methamphetamine is, what it does, why it seems appealing, and is dangerous. Includes many additional resources and where to get them. You can view a

webcast or order the video and other materials at the following web address: http://www.ncadi.samhsa.gov (or call 1-800-729-6686).

- *Tips for Teens: The Truth about Methamphetamine*, publication available from NCADI. You can view the publication online or order copies at the following web address: http://www.ncadi.samhsa.gov (or call 1-800-729-6686).

SAMHSA has many programs and grants in place and under development to address methamphetamine abuse in American Indian and Alaska Native communities. The following are examples of projects and programs which address methamphetamine abuse. Please refer to the sections below on Access to SAMHSA Grants and Technical Assistance Resources for guidance on applying for future grants.

- *SAMHSA/CSAT Earmark:* South Dakota Methamphetamine Treatment Initiative; funding level approximately $700,000; expands existing methamphetamine treatment program to meet growing need of providing treatment to individuals with methamphetamine use disorders; target population, including Native American clients, based on validation studies at South Dakota State Programs and at the Indian Health Service (IHS) facilities.
- *Access to Recovery and Methamphetamine:* Wyoming is focusing on Natrona County, the county with the second highest treatment need in the state and the "epicenter" of the current methamphetamine epidemic. In addition, Tennessee has a special focus on persons abusing or addicted to methamphetamine in rural or Appalachia areas, reaching out to community and faith-based organizations.
- *SAMHSA/CSAT Pregnant and Postpartum (PPW) Grant Program:* 3-yr. Grant program, awarded approximately $500,000 per grantee per year, funding period 9/2004 – 9/2007; Choctaw Nation, Chi Hullo Li Residential treatment program for women and their minor children, PPW Grantee; methamphetamine is the primary drug of choice of clients; client base is primarily American Indian.
- *Conduct Targeted Capacity Expansion (TCE) of Methamphetamine and Inhalant Prevention Interventions and/or Infrastructure Development:* 3-yr. Grant program, awarded approximately $350,000 per grantee per year, funding period 2003-2006; A total of 14 grants were awarded ranging from $300,000 to $350,000 for up to 3 years, with two awarded to build capacity in American Indian communities. 1) University of Arizona – to develop infrastructure to promote prevention of inhalant and methamphetamine use among an American Indian community ranging in age from 13-52, but focusing on adolescents; 2) Reno-Sparks Tribal Council – to develop expanded methamphetamine and inhalant prevention services for Native American youth 6-18, young adults, and parents. SAMHSA continues to expand treatment opportunities and capacity in local communities that are experiencing serious emerging drug problems. Between 2002 and 2005, Tribes and tribal organizations received more than $31 million through direct and indirect grant awards. It is anticipated that by close of FY 2006, 6-8 competitive grants will be awarded "off the shelf" (from existing applications). (Note: TCE grants provide funds to expand and/or enhance the community's ability to provide comprehensive, integrated, and community-based response to a targeted, well-documented substance abuse treatment capacity problem and/or improve the quality and intensity of services in a local area.)
- *Methamphetamine Center of Excellence:* This initiative, involving approximately $2 million in targeted treatment funds,

develops specialized treatment alternatives for methamphetamine users residing in the metropolitan communities of Phoenix and Tucson, as well as the Gila River Indian Community; CSAT's Pacific Southwest Addiction Technology Transfer Center (ATTC) is providing technical assistance to the Arizona Department of Health Services, Division of Behavioral Health in the design and implementation of their "Methamphetamine Treatment Centers of Excellence Initiative."

- *Prevention of Methamphetamine Abuse (FY 2006):* This CSAP announcement recently closed on May 16, 2006. Eligible applicants included federally recognized Tribes, State recognized Tribes, urban Indian organizations and Tribal organizations. Grants will support expansion of methamphetamine prevention interventions and/or infrastructure development to help communities expand prevention interventions that are effective and evidence-based with the goal of reducing or delaying the use of methamphetamine abuse.

Methamphetamine Behavioral Health Training at NNLEA Conference

SAMHSA coordinates closely with IHS to address methamphetamine abuse in AI/AN communities. SAMHSA is participating in the planning efforts, led by IHS, to partner with the National Native American Law Enforcement Association (NNALEA) on development of the 14th Annual NNALEA Training Conference which includes a major collaboration between federal law enforcement and behavioral health agencies. The law enforcement agencies are working closely with human service agencies to develop a methamphetamine abuse training track for law enforcement officers and officials in order to address the methamphetamine epidemic in Indian Country. SAMHSA and IHS are pleased to be partnering with organizations and agencies such as the National Congress of American Indians, White House Office of National Drug Control Policy, Department of Justice, Tribal Courts, Bureau of Indian Affairs, and others to organize the training. The conference will take place in Albuquerque, New Mexico, November 14-16, 2006.

Native American Law Enforcement Task Force

SAMHSA participates on the Native American Law Enforcement Task Force, chaired by Mr. Scott Burns, Deputy Director of State and Local Affairs of the White House Office of National Drug Control Policy. The monthly meetings are attended by representatives from Department of Justice, Department of the Interior, Bureau of Indian Affairs, Federal Bureau of Investigation, Drug Enforcement Administration, Environmental Protection Agency, Indian Health Service and Tribal Police. The main agenda for the monthly meetings is to address methamphetamine use in Indian Country utilizing a coordinated Federal effort in collaboration with the Tribes.

Department of Health and Human Services Collaboration

The Office of Minority Health is leading an effort and collaborating with SAMHSA, Office of Public Health and Science, National Institutes of Health, and Indian Health Service to support activities of the American Indian and Alaska Native Health Disparities Project with emphasis on methamphetamine abuse, suicide prevention, HIV/AIDS, and Hepatitis C. Approximately $1,000,000 has been identified to support this collaborative effort. The project is designed to conduct a national education and information outreach campaign targeting AI/AN communities and establish community-based promising practices for prevention, intervention, and treatment strategies.

SUICIDE PREVENTION

All of SAMHSA's programs to facilitate recovery from mental illnesses, to promote resilience, and to prevent and treat substance abuse disorders are essentially suicide prevention programs. The following are examples of SAMHSA's suicide prevention

programs and activities for American Indian and Alaska Native communities.

SAMHSA's budget request to the Administration for FY 2007 asks for nearly $3 million for a new American Indian/Alaska Native initiative, which would provide evidence-based programming on reservations and in Alaskan Native villages to prevent suicide and reduce the risk factors that contribute to youth suicide and violence.

Another new initiative has recently been announced, which started to take shape during this past National Congress of American Indians winter meeting and the Tribal Nations legislative summit. The Child, Adolescent, and Family Branch of the Center for Mental Health Services (CMHS) has identified funding to develop a Policy Academy on strategic planning for suicide prevention, intervention, and healing, focusing on children and youth in Tribal communities. In addition to CMHS, the National Steering Committee for the Tribal Policy Academy includes the Indian Health Service (IHS), Georgetown University Center for Children and Human Development, National Indian Health Board, National Congress of American Indians, and the National Indian Child Welfare Association. Planning is underway for the Policy Academy to take place in 2007.

In 2005, SAMHSA awarded the first cohort of grants under the Garrett Lee Smith Memorial Act State/Tribal Suicide Prevention program. There were 14 awards, including a grant to Arizona. These funds are available to help States and Tribes implement a suicide prevention network. SAMHSA Administrator, Mr. Charles Curie, established that a minimum of one award would be made to an American Indian/Alaska Native Tribe, Tribal organization, or Urban Indian Organization. In addition, the Native American Rehabilitation Association of Northwest, Inc. in Portland, Oregon, has received a $400,000 youth suicide prevention grant.

During his recent testimony before the Senate Indian Affairs Committee, Mr. Curie announced $9.6 million in funding for eight additional new Garrett Lee Smith grants – each approximately $400,000 per year for three years – to support national suicide prevention efforts.

Three Grants were specifically awarded to American Indians and Alaskan Natives:

- Manniilaq Association of Alaska to provide a variety of suicide prevention approaches to a region that has one of the highest youth suicide rates in the world;

- United Indian Involvement, Inc. to implement a Youth Suicide Prevention and Early Intervention Project targeting American Indian and Alaskan Native children and youth ages 10 to 24 in Los Angeles County;

- Montana Wyoming Tribal Leaders Council to provide suicide prevention efforts to six Montana and Wyoming American Indian reservations, serving Blackfeet, Crow, Northern Cheyenne, Fort Peck, Fort Belknap and Wind River populations.

In January 2005, SAMHSA launched the National Suicide Prevention Lifeline at 1-800-273-TALK. Lifeline services are offered to individuals in crisis as well as to friends and family members who believe someone they know may be at risk. Part of our immediate response at Red Lake (to the tragic shootings there) was to ensure that members of the Tribe and the larger community were aware of Lifeline services. The Lifeline is part of the National Suicide Prevention Initiative. This collaborative effort, led by SAMHSA, incorporates the best practices and research findings in suicide prevention and intervention. Along with the national Lifeline, the Federal Government launched a new Web site at www.suicidepreventionlifeline.org. SAMHSA has also worked to improve Lifeline services for American Indian communities, such as working with several tribes in the upper mid-West to incorporate the Lifeline into their suicide prevention activities. The National Suicide Prevention Lifeline has also worked closely with the Standing Rock community as well as with

local crisis centers in North and South Dakota to maximize hotline availability in this area. In addition, American Indian communities have been one of three target groups for a public education campaign about the Lifeline. We have provided several local organizations and tribes with information and resources to publicize the Lifeline and its suicide prevention and crisis intervention services.

CMHS has awarded a $1 million grant to the Oregon Health and Science University to establish the One Sky Center as an American Indian and Alaskan Native resource center. The center is developing a database of culturally appropriate suicide prevention programs, such as Zuni Life Skills and Gathering Nations.

Last October 2005, SAMHSA provided IHS with $200,000 to begin building greater capacity within Tribes to address suicide cluster response and suicide prevention among American Indians and Alaska Natives. This is a multiyear collaboration between CMHS, IHS, and Tribal communities nationwide. This funding supports programming and service contracts, technical assistance, and other related services. One example is the development of a community suicide prevention "toolkit." This toolkit will include information on suicide prevention, education, screening, intervention, and community mobilization.

Nationally, there are only 150 American Indian psychologists to serve a population for whom cultural sensitivity and understanding are vital to appropriate care. SAMHSA is creating a National Strategic Workforce Development Plan to Reduce Mental Health Disparities. We also are initiating a project to examine behavioral health care education and training and to advance efforts to integrate mental health and primary care for racial and ethnic minorities.

Emergency Response to Suicide

- SAMHSA has responded—and continues to respond to suicide crises in Indian Country with immediate and long-term action. SAMHSA's response to Red Lake was part of a multi-government show of support that brought together Federal, State, and local agencies as well as the State of Minnesota and the Chippewa Tribe. SAMHSA promptly provided staffing and resources to the Red Lake community. Within a week, SAMHSA staff members were onsite at the reservation.

- Together with the IHS and other DHHS agencies, we coordinated a Federal response to the tragedy. As other Federal agencies arrived to lend aid, a core group was prepared to guide their efforts to where the needs were greatest. Agencies included Public Health Service Commissioned Corps, Administration for Children and Families, Administration for Native Americans, and Office of Minority Health.

- SAMHSA conducted similar activities for Standing Rock. Through our Disaster Technical Assistance Center (DTAC), we helped to establish a Strategic Suicide Plan for the entire reservation, which spans North Dakota and South Dakota. Efforts have been made to reestablish program linkages between the reservation and the substance abuse treatment and prevention agencies within both States.

- Part of SAMHSA's response to Red Lake and Standing Rock was a SAMHSA Emergency Response Grant (SERG). When local resources are overwhelmed and other resources are unavailable, SAMHSA is authorized to serve as the funding source of last resort, providing grants for crisis mental health and substance abuse services. In the three years that the SERG program has existed, SAMHSA has given about one-third of the grants to American Indian communities.

- The Red Lake Chippewa community has received both an immediate and an intermediate SERG. The immediate SERG funded direct service providers to offer counseling and behavioral health outreach to the community at large. The Tribe has been incorporating traditional outreach methods to draw upon the healing powers and strengths of their cultural heritage. The intermediate SERG supports services for an additional year. Suicide prevention is a continuing need.

- The Standing Rock Sioux community has received a 1-year SERG. The grant provides outreach services and resource coordination to at-risk youth and to those families and tribal members affected by rash of suicides among youth and young adults on the Standing Rock reservation.

CHILD WELFARE

SAMHSA provides funding to National Center on Substance Abuse and Child Welfare - www.ncsacw.samhsa.gov. Report available: *Methamphetamine Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers***.** Available at the following web address: http://www.ncsacw.samhsa.gov/products.asp - click on "Meth and Child Safety."

The Best Beginning: Partnerships Between Primary Health Care and Mental Health and Substance Abuse Services for Young Children and Their Families, is an early childhood resource developed by the Georgetown University National Technical Assistance Center for Children's Mental health, under a cooperative agreement with SAMHSA. You can view the document online at http://gucchd.georgetown.edu (click on the link to the National Technical Assistance Center for Children's Mental Health). The document features eight innovative medical home practices that integrate behavioral health screening for the whole family, facilitate referrals to community services, and offer follow-up care.

In partnership with the National Association for Children of Alcoholics (NACoA), and White Bison, Inc., SAMHSA developed the Native American Children's Program Kit, a resource for providers working with American Indian/Alaska Native children of addicted parents. The Kit gives treatment providers and others the benefits of years of research and hands-on experience by NACoA and others in helping COAs and their families. The kit includes:

- Multi-age curriculum of educational activities
- Research-based tools to reach out to COAs
- Dynamic videos to illustrate concepts
- Program manual including start-up instructions and resources

You can order the Kit through the NCADI website at http://www.ncadi.samhsa.gov (or call 1-800-729-6686). In addition, you can view a related webcast on the NCADI website. For additional related resources, see http://ncadi.samhsa.gov/promos/coa/.

Regarding mental health services, SAMHSA also collaborates with IHS and the National Institute of Mental Health on the Circles of Care grant program. The Circles of Care program supports the implementation of mental health service models designed by American Indian/Alaska Native Tribal and urban Indian communities. The models use a systems-of-care community-based approach to mental health and other supportive services for children with serious emotional disturbances and their families. Seven Tribal communities are current grant recipients. (Note: The purpose of the Circles of Care program is to provide tribal and urban Indian communities with tools and resources to design systems of care to support mental health for their children, youth, and families in AI/AN communities. Circles of Care

grants support the building of infrastructure to increase the capacity and effectiveness of behavioral health systems serving AI/AN communities.)

In addition to the Circles of Care program, seven tribal organizations are among the current 56 grantees within SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Grant Program. This program provides funding for direct services to improve systems of care for children and adolescents with serious emotional disturbances and their families. Additional information can be found at the following website: http://store.mentalhealth.org/publications/allpubs/CA-0013/default.asp

National Mental Health Information Center, Child and Adolescent Mental Health website: http://www.mentalhealth.samhsa.gov/child/childhealth.asp

ACCESS TO SAMHSA GRANTS

SAMHSA'S policy is to level the playing field by ensuring that Tribal entities are eligible for all competitive grants for which States are eligible. Beginning in the FY 2005 grant cycle, Administrator Charles Curie established a SAMHSA policy on tribal eligibility stating that any grant announcement including State eligibility must automatically provide for Tribal eligibility unless there is a compelling reason to the contrary (such as statutory restrictions). Any reason for excluding Tribal entities from eligibility for the state-eligible grants needs to be justified and approved by the Administrator.

Recently, SAMHSA's Acting Deputy Administrator, Dr. Eric Broderick, has led an effort to develop a new Tribal Agenda for SAMHSA in order to continue to improve access for Tribes to SAMHSA grants. Activities underway or planned for the near future include improving SAMHSA grant announcements and grant review process to be more sensitive to AI/AN issues; revising SAMHSA's Tribal Consultation Policy based upon guidance from Tribal advisors; and organizing internal SAMHSA workgroups and involving more senior staff to address AI/AN issues.

On July 31 through August 2, Dr. Broderick and Crystal Saunders, SAMHSA's Director of Grants Review, convened a workgroup consisting of four Tribal representatives (including one Tribal leader) and appropriate SAMHSA staff for the purpose of reviewing and critiquing SAMHSA's FY 2006 Requests for Application (RFAs) in order to determine what language, requirements, and other elements could be changed and improved in order to create RFAs that would be more accessible and adaptable for AI/AN applicants. Gina Tyner-Dawson of Office of Minority Health provided the group with an overview of the Barriers report and related issues as background. The group provided many useful suggestions. Some of the suggestions will be simple to implement and some of them will require further discussion within SAMHSA before changes can be made. All participants agreed that it is important to have additional meetings in the future to continue this process.

During the month of July, 2006, SAMHSA assembled a technical writing team workgroup consisting of tribal leaders, tribal representatives, and key SAMHSA staff members for the purpose of revising the SAMHSA Tribal Consultation Policy. The workgroup met in mid-July at the United South and Eastern Tribes (USET) headquarters office in Nashville and made revisions to the existing draft SAMHSA Tribal Consultation Policy. SAMHSA will be reviewing the newly revised version internally, and then broadly distributing it to the Tribes, national and regional Tribal organizations, and others. The Tribal review and comments should be completed within a ninety-day period, September through December, 2006. The workgroup plans to meet one last time to produce the final version of the document which will then be forwarded for signature by HHS Secretary Michael Leavitt. The new Policy is expected to be approved and signed by February, 2007.

It is advisable to check frequently on the SAMHSA website (www.samhsa.gov) for press

releases on grant announcements especially early in the calendar year. The closing dates for receipt of most grant applications are generally between March and June. Please refer to the information provided on the SAMHSA website for technical assistance on preparing grant applications (see "Technical Assistance Resources" section below).

SAMHSA Fiscal Year 2007 Grant Opportunities

Refer to the Grants Home Page at http://www.samhsa.gov/grants06/default.aspx, as well as the Overview of Fiscal Year 2007 Grant Opportunities Chart at the following web address: http://www.samhsa.gov/Grants/2007/fy2007opps.aspx.

This listing allows potential applicants the opportunity to identify potential future funding opportunities and plan for the development of applications in their area of expertise and interest. The table for 2007 contains a general description of each project, the eligibility criteria, and the approximate funding amounts based on the President's FY 2007 budget request.

SAMHSA's Center for Mental Health Services may have eleven grant program opportunities: Conference Grants; Jail Diversion; Minority Fellowship; Statewide Family Networks; Statewide Consumer Networks Consumer/Consumer Supporter TA Centers; Alternatives to Restraint and Seclusion; Adolescents at Risk; Campus Suicide; Networking and Certifying Suicide Prevention Hotlines; and National Child Traumatic Stress Network. It is anticipated that approximately 90 grants totaling over $18 million will be awarded.

SAMHSA's Center for Substance Abuse Treatment may have six grant program opportunities: Targeted Capacity Expansion HIV/AIDS; Addiction Technology Transfer Centers (ATTCs); Recovery Community Services Program (RCSP); State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Health Disorders (COSIG); Access to Recovery Choice Incentive Program; and Access to Recovery (ATR) Methamphetamine. It is anticipated that approximately 96 grants totaling over $141 million will be awarded.

There may be changes to SAMHSA's grant announcements as mentioned above. Details regarding each specific funding opportunity will be provided on the SAMHSA website. When announced, the Request For Applications (RFA) can be found on the SAMHSA website at www.samhsa.gov. Call 800-729-6686 for applications kits for CSAT programs. Application kits for the CMHS programs are available by calling 800-789-2647. See below for additional resources for SAMHSA grant applicants.

TECHNICAL ASSISTANCE RESOURCES

Most valuable resource – **SAMHSA website at www.samhsa.gov.**

Technical assistance and training for SAMHSA grant applicants
http://www.samhsa.gov/Grants06/technical_assistance.aspx

Listed below are additional website resources that may be useful in preparing grant applications.

Center for Substance Abuse Prevention (CSAP)
http://prevention.samhsa.gov/

Center for Mental Health Services (CMHS)
http://www.mentalhealth.samhsa.gov/cmhs/

Center for Substance Abuse Treatment (CSAT)
http://csat.samhsa.gov/

National Clearinghouse for Alcohol and Drug Information (NCADI)
SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) is the Nation's one-stop resource for information about substance abuse prevention and addiction treatment.

http://www.ncadi.samhsa.org
1- (800) 729-6686
TDD: 1- (800) 487-4889

The National Mental Health Information Center
The Center is the source of information from the Center for Mental Health Services for publications, news and resources on mental health.
http://www.mentalhealth.samhsa.gov
1- (800) 789-2647
TDD: 1- (866) 889-2647

Addiction Technology Transfer Centers (ATTCs)
The Addiction Technology Transfer Center (ATTC) Network is dedicated to identifying and advancing opportunities for improving addiction treatment. ATTCs' vision is to unify science, education and services to transform the lives of individuals and families affected by alcohol and other drug addiction.
http://www.nattc.org

Centers for the Application of Prevention Technologies (CAPTs)
The CAPTs assist States/Jurisdictions and community-based organizations in the application of evidence-based substance abuse prevention programs, practices, and policies.
http://www.captus.org

Suicide Prevention Resource Center (SPRC)
SPRC promotes the implementation of the National Strategy for Suicide Prevention and enhances the nation's mental health infrastructure by providing states, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide.
www.sprc.org
1- (877) 438-7772

Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence
The FASD Center is a Federal initiative devoted to treating and preventing FASD.
www.fascenter.samhsa.gov
1- (866) 786-7327

CSAP's Prevention Pathways
Prevention Pathways is the gateway to information on substance abuse prevention programs, program implementation, evaluation, technical assistance, online courses, and other prevention resources.
http://preventionpathways.samhsa.gov/

The Drug Abuse Warning Network (DAWN)
A public health surveillance system that monitors drug-related visits to hospital emergency departments (EDs) and drug-related deaths investigated by medical examiners and coroners (ME/Cs).
http://dawninfo.samhsa.gov/

The Drug and Alcohol Services Information System (DASIS)
The primary source of national data on substance abuse treatment.
http://oas.samhsa.gov/dasis.htm

SAMHSA Office of Applied Studies, National Survey on Drug Use and Health (NSDUH)
http://oas.samhsa.gov/nhsda.htm

AI/AN National Resource Center
SAMHSA provides a variety of support modalities to AI/AN communities through the One Sky American Indian/Alaska Native (AI/AN) National Resource Center—co-funded by the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT). The center is dedicated to improving prevention and treatment of substance abuse among Native people. It is designed to work across all federal and state agencies that provide services to the Native communities. The objectives of the Center include:

- Promote and nurture effective and culturally appropriate substance abuse and prevention and treatment services for native populations;
- Identify culturally appropriate effective evidence-based substance abuse

prevention and treatment practices and disseminate them so that they can be applied successfully across diverse tribal communities;
- Provide training, technical assistance and products to expand the capacity and quality of substance abuse prevention and treatment practitioners serving AI/AN communities.

One Sky Center is housed at the Oregon Health & Science University in Portland, Oregon. The Center's reach is extended through the use of consultants and partners located throughout the United States. Conferences, workshops and distance learning technology is used to facilitate technology transfer, technical assistance, and consultation. In addition, the One Sky website maintains resources and information on culturally appropriate assessments and tools. For more information, you can access the website at www.oneskycenter.org**.**

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August 2006

Legislation:

Region X
Seattle, including AoA, CMS, and HRSA.

Medicare Prescription Drug Benefit Part D: The general discussion focused more on where we are now and what can we do to help. The majority of the questions and issues related to circumstances addressed in CMS letters to Plans and Tribal Leaders regarding directives on resolving problems between Plans and ITU Pharmacy network participants and beneficiary served. CMS described letters sent to All Part D Sponsors and Plans that was a reminder that Part D plans must coordinate benefits with other providers, including ITUs.

Medicare-Like-Rates (Section 506 of the Medicare Modernization Act): Although the MMA specified implementation by 12/04/2004, issues identified regarding the language were not resolved until September 2005, followed by OMB clearance, and finally published in the Federal Register on February 28, 2006 for a 60 day public comment period.

Deficit Reduction Act: The Tribes were very concerned with the "Proof of Citizenship" requirement under the DRA for Medicaid. There was strong objection to asking AI/ANs to establish/prove citizenship. Some AI/ANs were born at home with no attending doctor, resulting in no birth certificate. The use of Tribal Enrollment card was recommended to be used for evidence of citizenship.

Budget:

Region V
ORD, ACF, ORHA, OPA, SAMSHA, CMS

Leadership from seven Bemidji-area tribes in three states participated in the National Tribal Budget Consultation Session (May 16-17, 2006) and National Tribal Pandemic Influenza Preparedness Summit (May 18, 2006), giving a greater voice to the area tribes in national policy/decision making (in the past, only 1-2 Bemidji-area reps participated, usually the same reps). [ORHA funded travel.]

SAMHSA awarded the Mental Health Association of Milwaukee, WI a grant for Youth Suicide Prevention and Early Intervention Programs. The project sites include tribes.

ACF funded 32 Tribal title IV-B subpart 1 and title IV-B subpart 2 Child Welfare programs, 30 Child Care Development Fund (CCDF) programs, 12 Native Employment Works (NEW) programs, 9 Tribal Temporary Assistance for Needy Families (TANF) programs, and 4 Tribal 2-year Start-up Awards for Child Support Programs.

Conducted Child Support Enforcement grant application reviews and recommended approval of four Tribal IV-D Start-up applications. Reviewed and approved yearly Tribal IV-D grant applications from Comprehensive Tribes.

Region VI

The Pueblo of Zuni, Ponca Tribe of Oklahoma, Kaw Nation, Comanche Nation, and the Mescalero Apache Nation's Tribal Child Support Program Development Plans were approved and funded for approximately $500,000 each to design and implement a fully comprehensive child support program. ACF Region VI Tribal Support staff met with elected and senior tribal officials and provided technical assistance throughout the year to these tribal organizations.

Fifty-five tribes were awarded approximately $39,617,018 in child care funding and six tribes in Oklahoma requested set-asides in the amount of $706,008 for major construction/renovation for child care facilities. Region VI Tribal Child Care staff met with officials from the tribes and provided technical assistance throughout the year.

Fifty tribes were awarded funding for Title IV-B-1 and twenty-five tribes were awarded funding for Title IV-B-2 totaling approximately $3,970,000. ACF Region VI Tribal Child Welfare staff met with tribal officials and provided technical assistance throughout the year.

Other Budget Matters:

Region IV
CMS

Funds allocated for Travel - Consultation and CMS Day/Annual NAC meeting approximately $3.000.00

Section 4
Tribal Assessments of Consultation Efforts

SECTION 4: TRIBAL ASSESSMENTS OF CONSULTATION EFFORTS

The revised HHS Tribal consultation policy calls for each agency to solicit feedback from Tribes on HHS Tribal consultation sessions and efforts. The policy requires that this information be included in the Annual Tribal Consultation Report. Since 2005 is the first year that the new policy was implemented, consultation efforts were not monitored for reporting requirements. Thus, this section contains evaluation feedback reported from Tribes who participated in 2005 regional consultations. In 2006, additional focus will be placed on asking the Tribes to evaluate and share their impressions of HHS consultation efforts.

HHS ANNUAL TRIBAL BUDGET CONSULTATION SESSION FEEDBACK

HHS participants and Tribal Leaders agreed on the following suggestions for the next Annual Tribal Budget Consultation and the Divisional Budget Consultation Session.

Regarding the new format of two budget sessions there were various comments on how to improve the process overall. There were many questions and concerns as to what the difference was between the 1st Annual Divisional Session held in March and the 8th Annual Department Wide Tribal Budget Consultation Session. The participants at both sessions felt that the two sessions were repetitive. Other comments reflected the need to have only one session that occurred earlier in the spring and host a full two day session. The comments were very positive in having open roundtable discussions with HHS Leadership as opposed to having all presentations without have time to dialogue.

Suggestions were to have the agenda allow more time to discuss questions and comments after each Tribal presentation. The participant comments were very positive on the reflection of having the HHS Budget Council present to listen to the summaries of the presentations the day prior to this roundtable. Another suggestion was to organize the discussion around issues rather than around Federal agencies, and then invite all the Federal agencies who might be involved in addressing that issue to respond.

Regarding presentations, it was mentioned that more time is needed for both HHS and Tribal presentations to ensure a quality dialogue, even if this means fewer speakers or a full two-day session. Tribes desire the opportunity for senior HHS staff to engage in a full dialogue with the Tribal leaders. It would be preferable if Federal presenters would respond specifically to the Tribes' concerns and share any progress that has been made as a result of consultation.

REGIONAL TRIBAL CONSULTATION SESSION FEEDBACK

The evaluations received from participants reflected overall satisfaction with the consultation sessions. Over 800 tribal participants attended the consultations and Tribal representatives were particularly pleased with the opportunity to interact and present their concerns and suggestions with so many high level Federal and state representatives. Similarly, they found the opportunity to meet with other Tribal leaders helpful. The Tribes were also appreciative of the information provided on available grant funding opportunities, as well as the updates on state and Federal legislation affecting the Tribes, particularly the Medicare Modernization Act and drug benefit.

Tribal representatives provided additional feedback on what changes they would like to be made for future consultation sessions. For example, Tribes at the Region V would like to have more information on the distribution of federal funding from the top down and who makes decisions on the distribution of funds. They would also like to receive more information on Part D, ICWA/child welfare; consultation; AoA, ACF and HRSA funds; funding/access; behavior health/set asides and integrated care. Tribal

representatives in attendance at the Region VII consultation found that allowing emerging issues to be addressed as the topics were brought forward was most helpful. They also felt the information they received on the "good news and happenings" about Region VII tribes was received favorably. The tribes requested that information about funding opportunities and training announcements be included in the brochures. They particularly liked the cultural theme that was woven throughout the 2-day session helped to focus and showcase the tribe hosting the conference. Requests from the Region VIII consultation included: holding the consultation session in a location that is more convenient to tribal leaders and Region VIII agreed to hold pre-consultation meetings to encourage tribal leaders to formulate a list of tribal priorities. Region IX reported a successful consultation and the tribes would like to obtain more information on the following topics: domestic violence and elderly abuse, Part D, best practice models on methamphetamine prevention and treatment; health promotion and disease prevention; the federal budget process; Tribal TANF coordination and collaboration; HHS GPRA results; contract health services and IT and telemedicine. Tribes within Region 10 would like to hear information on current legislation that needs to be addressed immediately; information on the Secretary's 500/5,000 day plan; elderly issues and success stories on recovering meth users. They would also like to hear on the following topics at future consultation sessions: waivers for Medicaid users; successful meth recovery programs; contract support shortfalls and individual tribal impacts to programs or services; strategies to increase grant award success; Medicare, CMS; and ACF programs.

In addition, the Tribes want a mechanism to be established to keep them informed of new legislation and regulations on a continuing basis, rather than only once a year at consultation sessions. The Tribes would like more financial support to address health conditions such as obesity, diabetes and cancer. The Tribes would like authorization for their clinics to bill Medicaid for services provided to non-Native Americans.

In conclusion, it is hoped that HHS will continue to follow-up with tribes on the issues expressed at the consultations.

Appendices

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B. Regional Directors List

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C: ICNAA MEMBERS AND LIAISONS LIST

STAFF DIVISIONS			
Office Name	**Role in HHS**	**Tribal Liaison**	**Contact Information**
Immediate Office of the Secretary/ **Office of Intergovernmental Affairs (IOS/IGA)**	IGA facilitates communication regarding HHS initiatives as they relate to state, local, and tribal governments.	Stacey Ecoffey, Principal Advisor for *Tribal Affairs*	PH (202) 690-6060 FAX (202) 401-3207
Immediate Office of the Secretary/ **Executive Secretariat (IOS/ES)**	ES is responsible for reviewing and clearing documents designed for the Secretary's, Deputy Secretary's, and Chief of Staff's attention and approval, such as correspondence, regulations, reports to Congress, and decision memos.	Jamar Hawkins, *Policy Coordinator*	PH (202) 205-6380 FAX (202) 205-2135
Office of the Secretary/ **Assistant Secretary for Health (OS/ASH)**	ASH serves as the Secretary's primary advisor on matters involving the nation's public health and the Public Health Service.	Garth Graham, *Deputy Assistant Secretary for Health (Minority Health)*	PH (240) 453-2882 FAX (240) 453-2883
Office of the Secretary/ **Assistant Secretary for Administration and Management (OS/ASAM)**	ASAM provides leadership for HHS human resource policy, grants management, acquisitions, and departmental operations.	Catherine Backmeyer, *Special Assistant to the Assistant Secretary for Management & Administration*	PH (202) 205-5914 FAX (202) 401-5209
Office of the Secretary/ **Assistant Secretary for Resources and Technology (OS/ASRT)**	ASRT provides advice and guidance to the Secretary on budget, financial management, and information technology, and provides direction and coordination of these activities throughout the Department.	Amanda Jonas, *Program Analyst*	PH (202) 690-5616 FAX (202) 690-6896
Office of the Secretary/ **Assistant Secretary for Planning and Evaluation (OS/ASPE)**	ASPE is the principal advisor to the Secretary on policy development and is responsible for policy	Peggy Halpern, *Program Analyst*	PH (202) 260-0285 FAX (202) 401-6562

	coordination, legislation development, strategic planning, policy research and evaluation, and economic analysis.		
Office of the Secretary/ Office of the Assistant Secretary for Planning and Evaluation **Faith-Based and Community Initiatives (OS/ASPE/FBCI)**	FBCI's focus is on improving human services for the country's neediest citizens and welcomes the participation of faith-based and community-based organizations as valued and essential partners.	Greg Morris, *Associate Director*	PH (202) 401-3055 FAX (202) 401-3462
Office of the Secretary/ **Assistant Secretary of Public Affairs (OS/ASPA)**	ASPA serves as the Secretary's principal counsel on public affairs matters, provides centralized leadership and guidance for public affairs activities within the Department, and administers the Freedom of Information and Privacy Act.	Danielle Yaggie, *Confidential Assistant to the Assistant Secretary for Public Affairs*	PH (202) 205-1314 FAX (202) 690-5673
Office of the Secretary/ **Assistant Secretary for Preparedness and Response (OS/ASPR)**	ASPR serves as the Secretary's principal advisor on matters related to bioterrorism and other public health emergencies.	Dan Dodgen, *Human Services Policy Coordinator*	PH (202) 260-1949 FAX (202) 260-6056
Office of the Secretary/ **Office of General Council (OS/OGC)**	OGC provides quality representation and legal advice on a wide range of highly visible national issues.	Barbara Hudson, *Senior Attorney* Hilary.Frierson, *Attorney*	PH (301) 443-0406 FAX (301) 480-2161 PH (301) 443-1137 FAX (301) 480-2161
Office of the Secretary/ **Office of the Inspector General (OS/OIG)**	OIG protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs.	Melinda Golub, *Supervisory Auditor* Amitava (Jay) Mazumdar, *Senior Counsel*	PH (202) 205-9428 FAX (202) 205-9758 PH (202) 401-4049 FAX (202) 205-9758
Office of the Secretary/ **Office for Civil Rights (OS/OCR)**	OCR promotes and ensures that people have equal access to and opportunity to	Robinsue Frohboese, *Principal Deputy*	PH (202) 619-0403 FAX (202) 619-3437

	participate in and receive services in all HHS programs without facing unlawful discrimination.	*Director* Mary Graves	 PH (202) 619-3320 FAX (202) 619-1333

OPERATING DIVISIONS			
Office Name	**Role in HHS**	**Tribal Liaison**	**Contact Information**
Administration for Children and Families (ACF)	ACF is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities.	Sheila Cooper, *Director Program Operations Division, Administration on Native Americans*	PH (877) 929-9ANA PH (202) 690-5787 FAX (202) 690-7441
Agency for Healthcare Research and Quality (AHRQ)	AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.	Wendy Perry, *Senior Program Analyst*	PH (301) 427-1216 FAX (301) 443-0251
Administration on Aging (AoA)	AoA is one of the nation's largest providers of home- and community-based care for older persons and their caregivers.	Yvonne Jackson, *Director, Office of American Indian, Alaska Native and Native Hawaiian Programs*	PH (202) 357-3501 FAX (202) 357-3560
Agency for Toxic Substances and Disease (ATSDR)	ATSDR mission is to serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and disease related to toxic substances.	Leslie Campbell, *Environmental Health Scientist* Kristina Larson, *Health Education Specialist*	PH (404) 498-0457 FAX (404) 498-0073 PH (404) 498-0527 FAX (404) 498-1744
Center for Disease Control (CDC)	CDC is recognized as the lead federal agency for protecting the health and safety of people - at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships.	Ralph Bryan, *Senior CDC Tribal Liaison* Pelagie "Mike" Snesrud, *Senior CDC Tribal Liaison for Policy and Evaluation* Walter W. Williams, *Associate Director*	PH (505) 248-4142 FAX (505) 248-4393 PH (404) 498-2343 FAX (404) 498-2355 PH (404) 498-2310 FAX (404) 498-2360

		for Minority Health	
Centers for Medicare and Medicaid Services (CMS)	CMS's mission is to assure health care security for beneficiaries.	Dorothy Dupree, *Director, Tribal Affairs* Priya Helweg, *Policy Analyst*	PH (410) 786-1942 FAX (410) 786-1424 PH (410) 786-6128 FAX (410) 786-1424
Health Resources and Services Administration (HRSA)	HRSA's mission is to improve and expand access to quality health care for all.	Vacant, *Director, Office of Minority Health*	PH (301) 443-2964 FAX (301) 443-7853
Indian Health Service (IHS)	IHS's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.	Leo Nolan, *Senior Policy Analyst* Rae Jones, *Associate Director for Direct Services*	PH (301) 443-7261 FAX (301) 443-4794 PH (301) 443-1104 FAX (301) 443-4666
National Institutes of Health (NIH)	NIH is the steward of medical and behavioral research for the Nation.	John Ruffin, *Associate Director for Research on Minority Health* Lisa Evans, J.D., *Senior Advisor for Policy, National Center on Minority Health and Health Disparities*	PH (301) 402-1366 FAX (301) 402-7040 PH (301) 594-8748 FAX (301) 480-4049
Substance Abuse and Mental Health Services Administration (SAMHSA)	SAMHSA is charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.	Ginny Gorman-Gipp, *Senior Advisor, Tribal Affairs*	PH (240) 276-2204 FAX (240) 276-2240

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Region	**Office Name**	**Tribal Liaison**	**Contact Information**

Region 10: Seattle	Office of the Secretary/Intergovernmental Affairs	TBD, *Intergovernmental Affairs Specialist*	PH (617) 565-1500 FAX (617) 565-1491
Region 6: Dallas (Alternative)	Administration on Children and Families	Lisa Blackmon-Hansard, *Tribal Program Specialist*	PH (214) 767-8129 FAX (214) 767-8124

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D: HHS FUNDING FOR TRIBES

Table 1: HHS Funding for AI/AN Targeted Programs

Table 1 includes funding for programs that are earmarked exclusively for American Indians and Alaska Natives

DHHS FUNDING FOR AMERICAN INDIAN AND ALASKA NATIVE TARGETED PROGRAMS
(dollars in millions)

Program	FY 2006	FY 2007 CR	FY 2008 PB Total	+/- FY 2007 CR ($)	+/- FY 2007 CR (%)
Indian Health Service: /1	$3,883.0	$3,915.5	$4,127.3	+$211.9	+5.4%
Administration For Children & Families (ACF):					
Head Start	$185.4	$185.4	$185.4	--	--
Administration for Native Americans	44.3	44.3	44.3	--	--
Low Income Home Energy Assistance:	28.2	21.3	16.4	-4.9	-22.9%
Child Care Programs	99.6	99.6	99.6	--	--
Family Violence	12.5	12.5	12.5	--	--
Community Services Block Grant /2	4.6	4.1	--	-4.1	-100.0%
Community-Based Child Abuse Prevention	0.4	0.4	0.4	--	--
Promoting Safe and Stable Families	4.8	11.8	11.8	--	--
Tribal TANF	160.6	167.5	167.5	--	--
Tribal Work Program	7.6	7.6	7.6	--	--
Tribal Child Support /3	17.7	30.0	53.0	+23.0	+76.7%
Tribal Foster Care	--	--	30.0	+30.0	--
Child Welfare Services (IV-B)	5.7	5.7	5.7	--	--
Developmental Disabilities	0.2	0.2	0.2	--	--
Subtotal, ACF	$571.6	$590.5	$634.5	+$44.0	+7.5%
Administration on Aging:					
Grants to Tribes	$34.3	$34.3	$34.3	--	--
Centers For Disease Control and Prevention:					
Preventive Health Block Grant /2	$0.1	$0.1	--	-$0.1	-100.0%
Substance Abuse & Mental Health Services Administration	$8.5	$13.8	$8.5	-$5.2	-38.1%
HHS TOTAL	**$4,497.5**	**$4,554.1**	**$4,804.6**	**+$250.5**	**+5.5%**

/1 Includes insurance collections, rental of quarters and mandatory diabetes funding.
/2 The FY 2008 budget does not include funding for this program.
/3 Assumes additional Tribes will run their Child Support programs in FY 2008.

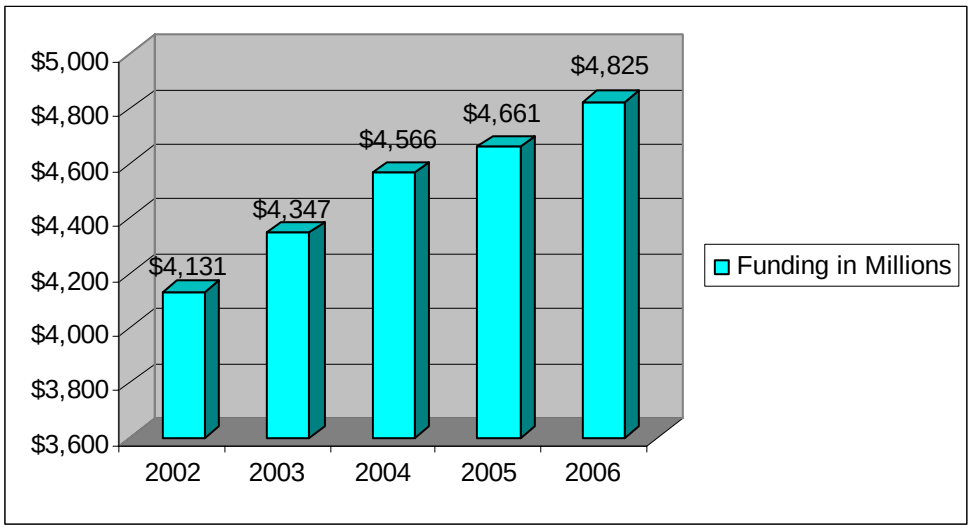
Table 2: HHS Funding for AI/AN Targeted and Discretionary Funding

Table 2 includes earmarked funds as well as discretionary funding or funding provided competitively to Tribes for the benefit of Tribes.

These data do not include HHS resources provided as a benefit to AI/AN individuals such as Medicare, Medicaid and Temporary Assistance for Needy Families (TANF) provided through state administered TANF programs

HHS Tribal Resource Trends – FY 2005 and FY 2006				
	FY05	FY 06	Change	Percent Change
IHS	$3,774,095,000	$3,898,246,000	$124,151,000	3.18%
ACF	$529,807,299	$569,406,255	$39,598,956	6.95%
NIH	$140,091,000	$139,807,000	-$284,000	-0.20%
SAMHSA	$45,929,000	$43,727,000	-$2,202,000	-5.04%
AoA	$34,591,000	$32,400,000	-$2,191,000	-6.76%
CDC	$69,118,917	$93,905,275	$24,786,358	26.40%
HRSA	$59,693,609	$39,906,419	-$19,787,190	-49.58%
ASH	$2,634,164	$3,947,737	$1,313,573	33.27%
AHRQ	$4,065,039	$3,618,247	-$446,792	-12.35%
CMS	$893,000	$409,285	-$483,715	-118.19%
TOTAL	**$4,660,918,028**	**$4,825,373,218**	**$164,455,190**	3.41%

Figure 1: HHS Tribal Resource Trends – FY 2002 to FY 2006



E: Tribal Consultation Policy (2006)

DEPARTMENT TRIBAL CONSULTATION POLICY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. INTRODUCTION

The Department of Health and Human Services (HHS) and Indian Tribes share the goal of eliminating health and human service disparities of American Indians and Alaska Natives (AI/AN) and ensuring that access to critical health and human services is maximized. To achieve this goal, and to the extent practicable and permitted by law, it is essential that federally-recognized Indian Tribes and the HHS engage in open, continuous, and meaningful consultation. True consultation leads to information exchange, mutual understanding, and informed decision-making. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994 and 2004, and an Executive Order in 2000.

2. BACKGROUND

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between AI/AN Indian Tribes and the Federal Government. This relationship is grounded in numerous treaties, statutes, and executive orders as well as political, legal, moral, and ethical principles. This relationship is not based upon race, but rather, is derived from the government-to-government relationship. The Federal Government has enacted numerous regulations that establish and define a trust relationship with Indian Tribes.

An integral element of this government-to-government relationship is that consultation occurs with Indian Tribes. This policy applies to all Divisions of the Department. Divisions shall provide an opportunity for Tribes to participate in policy development to the greatest extent practicable and permitted by law. Executive Memorandum entitled "Government-to-Government Relationship with Tribal Governments" reaffirmed this government-to-government relationship with Indian Tribes on September 23, 2004. The implementation of this policy is in recognition of this special relationship.

This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- Older Americans Act, P.L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended;
- Native Americans Programs Act, P.L. 93-644, as amended;
- Indian Health Care Improvement Act, P.L. 94-437, as amended;
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L.104-193;
- Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994;
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000; and
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004

3. TRIBAL SOVEREIGNTY

This policy does not waive any Tribal Governmental rights, including treaty rights, sovereign immunities or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other AI/AN persons or entities under Federal law.

Our Nation, under the law of the U.S. and in accordance with treaties, statutes, Executive Orders (EO), and judicial decisions, has recognized the right of Indian Tribes to self-government and self-determination. Indian Tribes exercise inherent sovereign powers over their members and territory. The U.S. continues to work with Indian Tribes on a government-to-government basis to address issues concerning Tribal self-government, Tribal trust resources, Tribal treaties and other rights.

The constitutional relationship among sovereign governments is inherent in the very structure of the Constitution, and is formalized in and protected by Article I, Section 8. Increasingly, this special relationship has emphasized self-determination and meaningful involvement for Indian Tribes in Federal decision-making (consultation) where such decisions affect Indian Tribes. The involvement of Indian Tribes in the development of public health and human services policy allows for locally relevant and culturally appropriate approaches to public issues.

Tribal self-government has been demonstrated to improve and perpetuate the government-to-government relationship and strengthen Tribal control over federal funding that it receives, and its internal program management.

4. POLICY

It is the HHS policy that consultation with Indian Tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes. Such actions refer to policies that have Tribal implications and that have substantial direct effects on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.

Nothing in this policy waives the Government's deliberative process privilege. For example, in instances where the Department is specifically requested by Members of Congress to respond to or report on proposed legislation, the development of such responses and of related policy is a part of the Executive Branch's deliberative process privilege and should remain confidential. In addition, in specified instances where Congress requires the Department to work with Tribes on the development of recommendations that may require legislation, such reports, recommendations or other products are developed independent of a Department position, the development of which is governed by Office of Management and Budget (OMB)-Circular A-19.

A. Each HHS Operating and Staff Division (Division) shall have an accountable process to ensure meaningful and timely input by Tribal officials in the development of policies that have Tribal implications.

B. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications, that imposes substantial direct compliance costs on Indian Tribes, or that is not required by statute, unless:

1. Funds necessary to pay the direct costs incurred by the Indian Tribe in complying with the regulation are provided by the Federal Government; or

2. The Division, prior to the formal promulgation of the regulation,
   a) Consulted with Tribal officials early and throughout the process of developing the proposed regulation;

   b) Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the *Federal Register* (FR), which consists of a description of the extent of the Division's prior consultation with Tribal officials, a summary of the nature of their concerns and the Division's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and

c) Made available to the Secretary any written communications submitted to the Division by Tribal officials.

C. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications and that preempts Tribal law unless the Division, prior to the formal promulgation of the regulation,

1. Consulted with Tribal officials early and throughout the process of developing the proposed regulation;

2. Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of the Division's prior consultation with Tribal officials, a summary of the nature of their concerns and the Division's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and

3. Made available to the Secretary any written communications submitted to the Division by Tribal officials.

D. On issues relating to Tribal self-governance, Tribal self-determination, Tribal trust resources, or Tribal treaty and other rights, each Division should explore, and where appropriate, use consensual mechanisms for developing regulations, including negotiated rulemaking.

E. The special "Tribal-Federal" relationship is based on the government-to-government relationship, however, other statutes and policies exist that allow for consultation with urban Indian organizations, non-federally recognized Tribal groups, governing bodies of Indian Tribes on Federal and State Reservations, State Recognized Tribes, other Indian organizations, Native Hawaiians, Native American Pacific Islanders (including American Samoan Natives), and other Native American groups, that, by the sheer nature of their business, serve American Indians, Alaska Natives or Native Americans and might be negatively affected if excluded from the consultation process. Section 9.B. of this policy describes when HHS will consult with other groups.

Even though some of the organizations and groups do not represent federally-recognized Tribal governments, the Department is able to consult with these groups individually. However, if the Department wants to include organizations which do not represent a specific federally-recognized Tribal government on advisory committees or workgroups then Federal Advisory Committee Act (FACA) requirements must be followed.

5. PHILOSOPHY

Indian Tribes have an inalienable and inherent right to self-governance. Self-governance means government in which decisions are made by the people who are most directly affected by the decisions. As sovereign nations, Indian Tribes exercise inherent sovereign powers over their members, territory and lands.

HHS has a long-standing commitment to working on a government-to-government basis with Indian Tribes and to work in partnership with AI/ANs. Also, HHS is committed to enhancing the collaboration among its Divisions to address Tribal issues and promoting the principle that each Division bears responsibility for addressing Tribal issues within the context of their mission.

The Office of Intergovernmental Affairs (IGA) is identified as the responsible organization within HHS for monitoring compliance with EO 13175 and the Department Tribal Consultation Policy. In addition, the Secretary has charged the Intradepartmental Council on Native American Affairs (ICNAA) to meet semi-annually and to provide advice on all HHS policies that relate to American Indians/Alaska Natives/Native Americans (AI/AN/NA). Regional consultation sessions have been developed as a systematic method to regularly consult with Indian Tribes on HHS programs at field locations. The goal of these efforts is to focus HHS on Tribal issues, to continue to enhance the government-to-government relationship between Indian Tribes and the U.S., as well as to make resources of HHS more readily available to Indian Tribes.

6. OBJECTIVES

- To formalize the requirement of HHS to seek consultation and the participation of Indian Tribes in policy development and program activities to ensure that health and human service priorities and goals are recognized.

- To establish a minimum set of requirements and expectations with respect to consultation and participation throughout HHS management, the Office of the Secretary (OS), Division, and Regional levels.

- To identify critical events at which Tribal consultation and participation will be required for all levels of HHS management, the OS, by each Division, and the Regional level.

- To identify events and partnerships that HHS would participate with Tribal and Native Organizations that will establish and foster partnerships to complement and enhance consultation with Indian Tribes.

- To promote and develop innovative methods of involving Indian Tribes in HHS policy development and regulatory processes.

- To uphold the responsibility of HHS to consult with Indian Tribes on new and existing health and human service policies, programs, functions, services and activities that have Tribal implications.

- To charge and hold accountable each of the Division Heads for the implementation of this policy.

- To be responsive to an Indian Tribe's request for consultation and technical assistance in obtaining HHS resources.

- To charge the Divisions with the responsibility for enhancing partnerships with Indian Tribes which will include, technical assistance, access to programs and resources.

- To provide a single point of contact within HHS for Indian Tribes at a level that has access to the Immediate Office of the Secretary (IOS), the Deputy Secretary, Regions, and Divisions. The Senior Advisor for Tribal Affairs will serve as the Department's point of contact in accessing department-wide information. Each Division will designate a representative through the ICNAA to serve as a Liaison and a Division point of contact for Indian Tribes.

- **ROLES**
  - **Indian Tribes**: The government-to-government relationship between the U.S. and Indian Tribes dictates that the principal focus for HHS consultation is with individual Indian Tribes.

  - **Tribal Organizations**: It is frequently necessary that the HHS communicate with Tribal organizations/committees to solicit consensual Tribal advice and recommendations. Although the special "Tribal-Federal" relationship is based on the government-to-government relationship with Indian Tribes, other statutes and policies exist that allow for consultation with other Tribal organizations. These organizations by the sheer nature of their business serve and represent Indian Tribes issues and concerns that might be negatively affected if these organizations were excluded from the consultation process.

  - **Native Organizations**: It is frequently necessary that HHS communicate with Native organizations/committees to solicit consensual advice and recommendations. Although the special "Tribal-Federal" relationship is based on the government-to-government relationship, other statutes and policies exist that allow for consultation with other Native organizations. These organizations, by the sheer nature of their business, serve and represent Native issues and concerns that might be negatively affected if these organizations were excluded from the consultation process. Section 9. B. of this policy describes when HHS will consult with other groups.

    Even though some of the organizations and groups do not represent federally recognized Tribal governments, the Department is able to consult with these groups individually. However, if the Department wants to include organizations which do not represent a specific federally recognized Tribal government on advisory committees or workgroups then FACA requirements must be followed.

4. **Office of Intergovernmental Affairs**: IGA is responsible for Department-wide implementation and monitoring of EO 13175 for HHS Tribal consultation. IGA serves as the Department's point of contact in accessing department-wide information. The single point of contact within the IGA for Indian Tribes and other Native organizations, at a level with access to all Divisions, is the Senior Advisor for Tribal Affairs. As a part of the IOS, the IGA's mission is to facilitate communication regarding HHS initiatives as they relate to Tribal, State, and local governments. IGA is the Departmental liaison to States and Indian Tribes, and serves the dual role of representing the States and Tribal perspective in the federal policymaking process, as well as, clarifying the federal perspective to States and Indian Tribes, including Tribal consultation.

5. **Assistant Secretary for Budget, Technology, and Finance**: The Assistant Secretary for Budget, Technology, and Finance (ASBTF) is the lead office for budget consultation for the overall departmental budget request. The IGA supports the ICNAA and ASBTF as the coordinating office within the IOS for communications among Regional Offices, Divisions and the ICNAA.

6. **Intradepartmental Council on Native American Affairs**: The Secretary's ICNAA plays a critical role in the execution of the HHS consultation policy. The ICNAA is charged to: (1) develop and promote an HHS policy to provide greater access and quality services for AI/AN/NAs throughout the Department, (2) promote implementation of HHS policy and Division plans on consultation with AI/AN/NAs and Indian Tribes in accordance with statutes and EOs, (3) promote an effective, meaningful AI/AN/NA policy to improve health and human services for AI/AN/NAs, (4) develop a comprehensive Departmental strategy that promotes self-sufficiency and self-determination for all AI/AN/NA people, and (5) promote the Tribal/Federal government-to-government relationship on an HHS-wide basis in accordance with EO 13175. The underpinning concept of the Council is the premise within HHS that all Divisions bear responsibility for the government's obligation to Native Americans.

7. **Regional Offices**: The ten (10) HHS Regional Offices share in the Department-wide responsibility to coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and States. The Regional Directors are the Secretary's immediate representatives in the field for the HHS. Each Regional Office is to conduct an annual regional Tribal consultation with Indian Tribes in their respective regions. Further, the Regional Directors will work closely with the respective Indian Tribes and State Governments to assure continuous coordination and communication between Tribes and States.

8. **HHS Divisions**: The Department has numerous Staff Divisions and Operating Divisions under its purview. Each of the these Divisions share in the Department-wide responsibility to coordinate, communicate and consult with Indian Tribes on issues that affect these governments. All Staff Divisions will comply with the Department Tribal Consultation Policy. Additionally, all Operating Divisions will comply with this policy and revise their own Tribal consultation policy or plan to conform to this Policy. All Divisions are responsible for conducting Tribal

consultation to the extent practicable and permitted by law on policies that have Tribal implications.

8. TRIBAL CONSULTATION

A. Consultation occurs:

1. When the HHS Secretary/Deputy Secretary, or their designee, and a Tribal President/Chair/Governor and/or elected/appointed Tribal Leader meet or exchange written correspondence to discuss issues concerning either party.

2. When a Division Head meets or exchanges written correspondence with an elected/appointed Tribal Leader to discuss issues or concerns of either party.

3. When a Regional Director, or their designee, who is the Secretary's representative in the field meets or exchanges written correspondence with an elected/appointed Tribal Leader to discuss issues or concerns of either party.

4. When the Secretary/Deputy Secretary/Division Head, or their designee, meets or exchanges written correspondence with a Tribal representative designated by an elected/appointed Tribal leader to discuss issues or concerns of either party.

B. Consultation Criteria: Trust between HHS and Indian Tribes is an indispensable element in establishing a good consultative relationship. The degree and extent of consultation will depend on the identified critical event. While this policy does not provide specific guidelines, Divisions shall utilize the following criteria to ensure that the requirements of this policy are satisfied.

1. Identify the Critical Event: Complexity, implications, time constraints, issue (funding, policy, programs)

2. Identify affected/potentially affected Indian Tribe(s), etc.

3. Determine level of Consultation – The level of consultation can be determined after considering the critical event and Indian Tribes affected/potentially affected.

    1) **Correspondence**: Written communications should clearly provide affected/potentially affected Indian Tribes of the critical event and the manner in which to provide comment. The HHS frequently uses a "Dear Tribal Leader Letter" (DTLL) format to notify individual Indian Tribes of consultation activities. Divisions should work closely with IGA if technical assistance is required for proper format, current mailing lists, and content.

    2) **Meeting(s)**: The Divisions shall convene a meeting with affected/potentially affected Indian Tribes to discuss all pertinent issues in a national or regional forum, or as appropriate, to the extent practicable and permitted by law, when the critical event is determined to have substantial direct impact.

Other types of meetings and/or conferences occur which may not be considered consultation sessions, but these meetings may provide an opportunity to share information, conduct workshops, and provide technical assistance to Indian Tribes.

3) **Notice**: Upon the determination of the level of consultation necessary, proper notice of the critical event and the level of consultation utilized shall be communicated to affected/potentially affected Indian Tribes using all appropriate methods including mailing, broadcast e-mail, FR, and other outlets. The FR is the most formal HHS form of notice used for consultation.

4) **Receipt of Comment**: The Division shall develop clear and explicit instructions for the submission of comments.

5) **Reporting of Outcome**: The Division shall report on the outcomes of the consultation.

C. **Tribal Resolution**: Communications from Indian Tribes frequently come in the form of Tribal resolutions. These resolutions may be the most formal declaration of an Indian Tribe's position for the purpose of Tribal consultation. Once the Division receives a Tribal resolution, the Division should respond appropriately. Appropriate response may include Tribal consultation.

D. **Schedule For Consultation**: Divisions must establish and adhere to a formal schedule of meetings to consult with Tribal governments and representatives concerning the planning, conduct, and administration of applicable activities. Divisions must involve Tribal representatives in meetings at every practicable opportunity. Divisions are encouraged to establish additional forums for Tribal consultation and participation, and for information sharing with Tribal leadership. Consultation schedules should be forwarded to IGA to be posted on the IGA website and to check for duplication or conflicts with other national Tribal events and HHS consultation sessions.

E. **Policy Development Through Tribal Consultation Process**: The need to develop a policy may be identified from within the Division or may be identified by Indian Tribes. This need may result from external forces such as Executive, Judicial, or Legislative Branch directives. Once the need to develop a policy is identified the consultation process must begin in accordance with critical events and level of consultation. The Divisions may request technical assistance from IGA for the Tribal consultation process.

9. CONSULTATION PROCESS

A. Tribal

1. Work sessions will be held to solicit official Tribal comments and recommendations on policy and budget matters affecting Indian Tribes. These sessions at roundtables, forums and meetings will provide the opportunity for meaningful dialogue and effective participation by Indian Tribes.

2. Indian Tribes have the ability to meet one-on-one with a Division Head or designated representative to consult on issues specific to that Indian Tribe.

3. The IGA or Division upon completion of a consultation session will document and follow-up on any unresolved issues that would benefit from ongoing involvement of Indian Tribes in implementation and evaluation.

4. IGA will consult with Tribally-elected/appointed Leader on the Tribal consultation policy to ensure effective and meaningful participation.

5. The HHS Tribal consultation policy will be posted on the HHS website homepage and offered to appropriate Tribal and Native organization websites.

6. IGA will continue to inform Indian Tribes on the Tribal Consultation Policy by conducting meetings, roundtables, teleconferences, forums, and placing information on the HHS website homepage and other appropriate websites.

7. Specific mechanisms that will be used to consult with Tribal governments include, but are not limited to: mailings, meetings, teleconferences, and roundtables.

B. Consultation with Other Groups: In cases where the government-to-government relationship does not exist, consultation is encouraged to the extent that a conflict of interest does not exist with Federal statutes or the Division authorizing legislation. Some aspects of this consultation are set out in statute and administrative policy.

Even though the organizations and/or groups do not represent federally recognized Tribal governments, the Department is able to consult with these groups individually. However, if the Department wants to include organizations which do not represent specific federally-recognized Tribal governments on advisory committees or workgroups then FACA requirements must be followed. The intergovernmental committee exemption to FACA is found under 2 U.S.C. 1534. As a result, the Department is required to adhere to FACA when such organizations are made a part of an advisory committee or workgroup.

The Secretary's ICNAA is responsible for ensuring inclusion of the organizations and groups in policies affecting Native Americans Department-wide. The ICNAA will work closely with IGA, Regional Directors and the Divisions to identify those instances when other Native American non-governmental organizations and groups may be negatively affected if excluded from the consultation process such as urban Indian organizations, non-federally recognized Tribal groups, governing bodies of

Indian Tribes on Federal and State Reservations, State Recognized Tribes, other Indian organizations, Native Hawaiians, Native American Pacific Islanders (including American Samoan Natives), and other Native American groups that, by the sheer nature of their business, serve American Indians, Alaska Natives or Native Americans.

Although consultation may be allowed with these organizations, non-federally recognized Tribes and Tribal organizations listed above do not fall under the intergovernmental committee exemption to FACA found under 2 U.S.C. 1534. As a result, the agency is required to adhere to FACA when such organizations are made a part of an advisory committee or workgroup.

The ICNAA will work with IGA and the Divisions to facilitate any required consultation forums, the level of consultation required, recording of meetings, evaluate the results, determine whether additional consultation on policy items may be needed, and report to the affected Native American groups and non-governmental Indian and Native organizations.

C. States:

1. In some instances, the authority and appropriations for HHS programs and services to Indian Tribes flow through the States for the benefit of Indian Tribes, based on statute, regulation or HHS policy. It is important that HHS facilitate collaboration between States and Indian Tribes to assist with consultation in the same manner should HHS programs and services be provided directly to an Indian Tribe.

2. When States are authorized to administer HHS programs, services, and funding for the benefit of Indian Tribes and AI/ANs, IGA will collaborate with Divisions to assist States in developing mechanisms for consultation with Indian Tribes before taking any actions that have substantial direct effects on Indian Tribes. HHS will recommend the development of State plans for Tribal consultation. States will receive HHS technical assistance in developing these plans.

3. IGA, Regional Directors, and Divisions will assist States to consult with Indian Tribes in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy. Divisions will communicate the input received through Tribal consultation to the States through the appropriate program(s) and work with the Regional Directors to facilitate collaboration between Indian Tribes, States, and HHS.

4. IGA will assist Divisions in helping States develop and implement plans on Tribal consultation to assist States with intergovernmental communications with Indian Tribes. Regional Directors and Regional Office staff will provide technical assistance to States and Indian Tribes for the Tribal consultation process.

5. When a Division foresees the possibility of a conflict between Tribal and State laws and Federally protected interests within its area of regulatory responsibility, the Division shall consult, to the extent practicable and permitted by law, with appropriate Indian Tribes and/or States in an effort to facilitate a dialogue.

6. IGA and Regional Directors are encouraged to invite and include State governmental, health, and human services experts in the Annual Regional Tribal Consultation Sessions whenever Indian Tribes express that State/Tribal dialogue is necessary to enhance and strengthen HHS health and human services and programs.

7. IGA shall provide guidelines that define how the Divisions will monitor and evaluate State plans to meet Tribal consultation meetings, forums, and/or sessions with Indian Tribes for HHS programs and services administered by or through a State for Indian Tribes. HHS will address State plans in situations where the evaluation has identified deficiencies in the consultation process as set forth in this policy, and work closely with States to strengthen consultation necessary for HHS funded programs and services for Indian Tribes and AI/ANs.

8. Regional Directors and HHS Divisions will measure and report on their interaction with States to facilitate and provide Tribal consultation technical assistance to States and Indian Tribes. Divisions will include their efforts in the IGA Annual Tribal Consultation Report.

D. Regional Tribal Consultation:

1. The HHS Regional Tribal Consultation Sessions are designed to solicit Indian Tribe's priorities and needs on health and human services and programs. The Sessions will provide an opportunity for Indian Tribes to articulate their comments and concerns on budgets, regulations, legislation and HHS health and human services policy matters.

2. Regional Offices/Directors and Divisions will work collaboratively with the Indian Tribes in their respective Regions on the development of consultation meetings, roundtables and annual sessions.

3. Regional Offices/Directors and Divisions will work with the Indian Tribes to identify regional Tribal and Native organizations that assist in representing the Indian Tribes in planning Tribal consultation sessions.

4. Regional Offices/Directors and Divisions will work collaboratively with the Indian Health Service (IHS) Area Directors in communicating and coordinating on issues and concerns of Indian Tribes in those respective regions or areas.

5. Regional Offices/Directors and Divisions will work collaboratively to facilitate Tribal-State relations as they affect Indian Tribes and AI/ANs.

10. ESTABLISHMENT OF JOINT TRIBAL/FEDERAL WORKGROUPS AND/OR TASK FORCES

A. Consultation:

1. **New Policy**: When new or revised national policy/policies affect an Indian Tribe/Tribes, HHS may establish a workgroup and/or task force to develop recommendations on various technical, legal, or policy issues. In such cases, the following process is generally followed:

   a) **Joint Tribal/Federal Workgroups and/or Taskforces**: Although the special "Tribal-Federal" relationship is based in part on the government-to-government relationship it is frequently necessary for HHS to establish Joint Tribal/Federal Workgroups and/or Task Forces to complete work needed to develop new policies, practices, issues, and/or concerns and/or modify existing policies, practices, issues, and/or concerns. These Joint Tribal/Federal Workgroups and/or Task Forces do not take the place of Tribal consultation, but offer an enhancement by gathering individuals with extensive knowledge of a particular policy, practice, issue and/or concern to work collaboratively and offer recommendations for consideration by federally recognized Tribal governments and federal agencies. The subsequent work products and/or outcomes developed by the Joint Tribal/Federal Workgroup and/or Task Forces will be handled in accordance with this policy.

   b) **Membership Notices**: The Department is allowed to meet with various representatives of organizations on an individual basis. However, if the Department or Division desires to form an advisory committee or workgroup, which includes representatives from organizations, assurance must be provided to the IGA which demonstrates compliance with FACA. If such organizations are exempt from FACA because of the intergovernmental committee exemption found under U.S.C. 1534, then documentation must be provided to IGA. In order to assure compliance with FACA requirements and exemptions, advice from agency counsel may be sought prior to formation of advisory committees or workgroups.

   c) **Meeting Notices**: The purpose, preliminary charge, time frame, and other specific tasks shall be clearly identified in the notice. All meetings should be open and widely publicized ideally through IGA or the Division initiating the policy.

   d) **Workgroups**: Tribal membership should be selected based on the responses received from prospective volunteers as a result of the notice, and if possible, should represent a cross-section of affected parties. HHS staff may serve in a technical advisory capacity.

B. Participation:

1. **Attendance at Meetings**: Workgroup members must make a good faith effort to attend all meetings. Other individuals may accompany members, as that member believes is appropriate to represent his/her interest.

2. **Appointment of Alternates**: Each workgroup member may appoint an alternate by written notification. In cases where an elected Tribal leader appoints an alternate who is not an elected official, the alternate shall represent the primary member on a workgroup. The alternate will have the same voting rights as the primary member, as designated in the letter by that Tribal leader.

3. **Workgroup Protocols**: The workgroup may establish protocols to govern the meetings. Such protocols will include, but are not limited to the following:
   a) Selection of workgroup co-chairs, if applicable

   b) Role of workgroup members

   c) Process for decision-making (consensus based or otherwise)

   d) Process for determining drafting and availability of all final workgroup products and documents

4. **Workgroup Charge**: Prior to the workgroup formulation, the HHS may develop an initial workgroup charge in enough detail to define the policy concept. The workgroup will develop recommendations for the final workgroup charge for the approval of the HHS Secretary, the IGA Director or the Division head.

5. **Workgroup Final Products**: Once a final draft of the workgroup has been created by the workgroup the following process will be used to facilitate additional consultation:

   a) Upon completion, the draft policy documents will be distributed informally to Indian Tribes, National Tribal and Native Organizations for review and comment and to allow for maximum possible informal review.

   b) Comments will be returned to the workgroup, which will meet in a timely manner to discuss the comments and determine the next course of action.

   c) If the proposed policy is considered to be substantially complete as written, the workgroup will forward the draft policy to the HHS Secretary as final recommendation for consideration.

   d) The workgroup will also recognize any contrary comments in its final report.

   e) If it is determined that the policy should be rewritten, the workgroup will rewrite and begin informal consultation again at the initial step above.

f) If the proposed policy is generally acceptable to the HHS Secretary, final processing of the policy by the workgroup will be accomplished.

6. **Recommendations and Policy Implementation**: All final recommendations made by the workgroup should be presented to the Secretary. Before any final policy decisions are adopted within HHS, the proposed policy shall be widely publicized and circulated for review and comment to Indian Tribes, National Tribal Organizations, other Native organizations, and within HHS. Once the consultation process is complete and a proposed policy is approved and issued, the final policy shall be broadly distributed to all Indian Tribes.

11. HEALTH AND HUMAN SERVICES BUDGET FORMULATION

1. **Performance Budget Formulation**: HHS ensures the active participation of Indian Tribes in the formulation of the HHS performance budget request as it pertains to Indian Tribes.

2. **Operating Division Consultation Plan**: Each Division Consultation Plan includes a description of how the Division consults with Indian Tribes regarding the formulation of the annual budget.

3. **National Divisional Tribal Budget Formulation and Consultation Session**: A national budget formulation session that includes each Operating and Staff Division that has involvement in Tribal activities is conducted annually to give Tribes and Tribal Organizations the opportunity to present their health and human services priority recommendations as a comprehensive set of national priorities and a proposed budget request. The intent of these sessions is to permit Divisions to consider Tribal comments as they prepare their budgets for submission to the Office of the Secretary. In order for Divisions to receive and consider Tribal recommendations in the development of the budget request, this session is conducted no later than March 15 of each year.

4. **National HHS Tribal Budget Formulation and Consultation Session**: An annual, Department-wide Tribal budget formulation and consultation session is conducted to give Indian Tribes the opportunity to present their budget priorities/recommendations to the Department with participation of the ICNAA to ensure priorities/recommendations are addressed as HHS prepares to receive the budget requests of its Divisions. The session is convened in May of each year as a means for final input in the development of the Department's budget submission to OMB.

5. **Intradepartmental Council on Native American Affairs:** The ICNAA represents the internal HHS team providing direction across the Divisions for AI/AN/NA issues. The Tribal priorities and budget recommendations presented at the Divisional Meeting and Regional Consultation Sessions are compiled by the IGA and presented to the ICNAA.

One of the primary responsibilities of IGA/ICNAA is to solicit Tribal input in establishing the health and human service budget priorities and recommendations for their respective Divisions.

The health and human service priorities established by Indian Tribes are used to inform the development of the Divisions' annual performance measures for improving health and human services, which are linked to their budget requests.

6. **Budget Information Disclosure**: HHS provides Indian Tribes the HHS budget related information on an annual basis: appropriations, allocation, expenditures, and funding levels for programs, services, functions, and activities.

12. MEASURING HHS TRIBAL CONSULTATION PERFORMANCE AND COLLABORATION

As part of the IGA Annual Tribal Consultation Report, Divisions will measure and report results and outcomes of their Tribal consultation performance to fulfill the government-to-government relationship with Indian Tribes.

The Department mission and the Department-wide performance objectives are designed to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health and social services.

Divisions shall address the Department's mission and performance objectives in carrying out the Department Tribal Consultation Policy.

Generally, one such objective promotes increasing access to health care (closing the gaps in health care). Specifically, Division performance is measured on the division's ability to increase access to quality health care services for AI/ANs, and to eliminate racial and ethnic health disparities. Another objective is to expand consumer choices in health care and human services. Other Division objectives emphasize preventive health measures, health outcomes, improve the quality of health care, and improve the well being and safety of families and individuals, especially vulnerable populations. Objectives also require Divisions to strengthen American families, including, but not limited to, increase the proportion of low-income individuals and families, including those receiving welfare and who improve their economic condition, and improving the economic and social development of distressed communities. Objectives call for Divisions to reduce regulatory burden on providers and consumers of HHS services.

In meeting HHS objectives for the Department Tribal Consultation Policy, Divisions provide a status report on the outcome of Tribal budget recommendations developed through the budget formulation process as part of the budget process defined in Section 11, HHS Budget Formulation. They shall also record, evaluate and report on the Annual Regional Tribal Consultation Sessions as described in Section 9, Consultation Process.

Divisions and Indian Tribes will also promote a cooperative atmosphere to gather, share, and collect data to demonstrate the effective use of federal resources in a manner that is consistent with the Government Performance and Results Act (GPRA) performance measures and the OMB Program Assessment Rating Tool (PART); Divisions shall consult, to the greatest extent practicable and permitted by law, with Indian Tribes before taking actions that substantially affect Indian Tribes, including regulatory practices on federal matters and unfunded mandates;

1. The impact of Division activities on Tribal trust resources shall be adequately assessed and Tribal interests considered before activities are undertaken;

2. the removal of governmental procedural impediments to work directly with Indian Tribes on activities that affect trust property or governmental rights of the Indian Tribes;

3. the Divisions will work to reduce regulatory burdens by streamlining the application process for and increase the availability of waivers to Indian Tribes; and,

4. divisions operate in a collaborative manner to accomplish the goals of Executive Order 13175 and this policy.

13. EVALUATION, RECORDING OF MEETINGS, AND REPORTING

The consultation process and activities conducted within the policy should result in a meaningful outcome for the Department and for the affected Indian Tribes. In order to effectively evaluate the results of a particular consultation activity and the Department's ability to incorporate Indian Tribes' consultation input, the Department should measure, on an annual basis, the level of satisfaction of the Indian Tribes.

1. Divisions should develop and utilize appropriate evaluation measures to assess Indian Tribes' response to Department consultation conducted during a specific period to determine if the intended purpose of the consultation was achieved and to receive recommendations to improve the consultation process. The Divisions will maintain a record of the consultation, evaluate whether the intended results were achieved, and report back to the affected Indian tribe(s) on the status or outcome, including, but not limited to, the annual sessions conducted below.

2. At a minimum, HHS conducts one Annual Tribal Budget Consultation Session to ensure the active participation of Indian Tribes in the formulation of the HHS performance budget request as it pertains to Indian Tribes, which is usually held at the HHS Headquarters in Washington, DC in the spring. The IGA shall post a record of the annual session on the IGA website within 90 days.

3. At a minimum, HHS Regional Directors conduct an Annual Regional Tribal Consultation for Divisions to consult with Indian Tribes. These sessions shall provide an opportunity to receive the Indian Tribes priorities for budget, regulation, legislation, and other policy matters. Unless otherwise specified, the IGA Annual

Consultation Report shall provide an annual reporting mechanism for this purpose and all Divisions are required to participate in this report.

4. Upon completion of consultation, the Division, and affected Indian Tribes, shall determine if there are any unresolved issues that would benefit from ongoing involvement of Indian Tribes in implementation and evaluation, including, but not limited to: assess the impact of the Division's plans, projects, programs and activities on Tribal and other available resources; removing any procedural impediments to working directly with Indian Tribes; and working collaboratively with other Federal agencies in these efforts.

5. IGA, Regional Directors and the Divisions shall ensure the annual department-wide Tribal Budget Consultation session and the Annual Regional Tribal Consultation Sessions include evaluation components for receipt of verbal and written comments from participating Indian Tribes, HHS Divisions, and other invited participants to obtain immediate feedback on the consultation session conducted.

6. With the assistance of Indian Tribes, IGA will measure the implementation and effectiveness of this Policy. IGA will assess the Department Tribal Consultation Policy at the Annual Regional Consultation Sessions and the HHS Annual Budget Consultation Session, and utilize comments from Indian Tribes and federal participants to determine whether amendment to the Policy may be required. IGA should fully consider reconvening the Tribal Consultation Policy Revision Workgroup (TCPRW) that helped to form this policy or a similar workgroup to assist IGA in making this determination.

7. The Divisions and the Regional Directors will report at each regional Tribal consultation session, what actions were taken as a result of the previous regional Tribal consultation session and describe how HHS addressed the consultation evaluation comments received by participants.

8. Divisions are required to submit to IGA the fiscal year Tribal consultation information within 90 days from the end of the fiscal year. IGA shall compile the Division submissions, and publish and distribute the information to the Indian Tribes within 60 days from receipt of the Division reports. The IGA, Regional Directors and Divisions shall also report the Department's views on the level of attendance and response from Tribal leaders during the Annual Department-Wide Tribal Budget Consultation Session and the Annual Regional Tribal Consultation Sessions, including evaluative comments, and provide advice and recommendations regarding the Tribal consultation process. The IGA shall post on the website, the IGA Annual Tribal Consultation Report, including the evaluation results at http://www.hhs.gov/ofta.

9. All national and regional consultation meetings and recommended actions shall be formally recorded and made available to Indian Tribes. Once the consultation process is complete and any policy decision is finalized, all recommended follow-up actions adopted shall be implemented and tracked by the appropriate Division and reported to the Indian Tribes in the IGA Annual Tribal Consultation Report.

14. CONFLICT RESOLUTION

The intent of this policy is to provide increased ability to solve problems. However, inherent in the government-to-government relationship, Indian Tribes may elevate an issue of importance to a higher or separate decision-making authority.

Agencies shall consult with Indian Tribes to establish a clearly defined conflict resolution process under which Indian Tribes: 1) bring forward concerns which have a substantial direct effect, and 2) apply for waivers of statutory and regulatory requirements that are subject to waiver by the Division.

Nothing in the Policy creates a right of action against the Department for failure to comply with this Policy.

15. SUPERSEDURE

Department Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations dated August 7, 1997. Tribal Consultation Plan, U.S. Department of Health and Human Services, Office of the Secretary – Staff Divisions

16. EFFECTIVE DATE

Department Tribal Consultation Policy, U.S. Department of Health and Human Services
This policy is effective on the date of the signature by the Secretary of Health and Human Services. (Signed January 14, 2005).

This policy replaces the Tribal Consultation Plan for the Office of the Secretary Staff Divisions and it applies to all Operating Divisions. Operating Divisions shall complete necessary revisions to their existing Division consultation policy/plan to conform to the revised Department Tribal Consultation Policy.

17. SUMMARY

In developing this Policy a wide range of needs across HHS, as well as the unique characteristics of the Divisions that comprise it were taken into account. As there is diversity among the Divisions, there is also a need for Divisions to be responsive to changes, which occur within their programs and within their constituency. Hence, it is important that consultation plans developed by Divisions remain dynamic, changing as circumstances and Indian Tribes input indicate. The Department should strengthen and make every effort with those of other departments and agencies. Such intra-governmental coordination will benefit the departments and agencies as well as the Indian Tribes.

18. DEFINITIONS

1. **Agency** – Any authority of the United States that is an "agency" under 44 USC 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC 3502 (5).

2. **Communication** – The exchange of ideas, messages, or information, by speech, signals, writing, or other means.

3. **Consultation** – An enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

4. **Coordination and Collaboration –** Working and communicating together in a meaningful government-to-government effort to create a positive outcome.

5. **Critical Events** – Planned or unplanned events that have or may have a substantial impact on Indian Tribes or Native communities, e.g., issues, polices, or budgets which may come from any level within HHS.

6. **Deliberative Process Privilege** – Is a privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.

7. **Executive Order** – An order issued by the Government's executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act).

8. **Federally Recognized Tribal governments** – Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of federally recognized Indian Tribes.

9. **HHS Tribal Liaisons** – HHS staff designated by the head of an HHS Division that are knowledgeable about the Division's programs and budgets, and have ready access to senior program leadership, and are empowered to speak on behalf of that Division for AI/AN/NA programs, services, issues, and concerns.

10. **Indian Organization** – Any group, association, partnership, corporation, or legal entity owned or controlled by Indians, or a majority whose members are Indians.

11. **Indian Tribe** – Any Indian Tribe, band, nation or other organized group or community including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. (25 U.S.C. Sec 450b).

12. **Indian** – Indian means a person who is a member of an Indian tribe. 25 U.S.C. 450b(d). Throughout this policy, Indian is synonymous with American Indian/Alaska Native.

13. **Intradepartmental Council on Native American Affairs (ICNAA)** – Authorized by the Native American Programs Act of 1974 (NAPA), as amended. The ICNAA serves primarily to perform functions and develop recommendations for short, intermediate, or long-term solutions to improve AI/AN/NA policies and programs as well as provide recommendations on how HHS should be organized to administer services to the AI/AN/NA population.

14. **Joint Tribal/Federal Workgroups and or/Task Forces** – A group composed of individuals who are elected Tribal officials, appointed by federally recognized Tribal governments and/or federal agencies to represent their interests while working on a particular policy, practice, issue and/or concern.

15. **Native American (NA)** – Broadly describes the people considered indigenous to North America.

16. **Native Hawaiian** – Any individual whose ancestors were natives of the area, which consists of the Hawaiian Islands prior to 1778 (42 U.S.C. 3057k).

17. **Native Organization –** A nongovernmental body organized and operated to represent the interests of a group of individuals considered indigenous to North American countries. Organizations that represent the interests of individuals do not fall under the intergovernmental committee exemption to FACA found under 2 U.S.C. Sec 1534. Therefore, the Department is required to adhere to FACA if representatives of those organizations are included on advisory committees or workgroups.

18. **Non-Recognized Tribe** – Tribe with whom the Federal Government does not maintain a government-to-government relationship, and to which the Federal Government does not recognize a trust responsibility.

19. **Policies that have Tribal Implications** – Refers to regulations, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.

20. **Public Participation** – When the public is notified of a proposed or actual action, and is provided meaningful opportunities to participate in the policy development process.

21. **Reservation** – Lands reserved with the Federal Government for Tribal use and are usually held in trust by the Federal Government or within certain defined boundaries.

22. **Self Government** – Government in which the people who are most directly affected by the decisions make decisions.

23. **Sovereignty** – The ultimate source of political power from which all specific political powers are derived.

24. **State Recognized Tribes** – Tribes that maintain a special relationship with the State government and whose lands and rights are usually recognized by the State. State recognized Tribes may or may not be federally recognized.

25. **Substantial Direct Compliance Costs** – Those costs incurred directly from implementation of changes necessary to meet the requirements of a federal regulation. Because of the large variation in Tribes, "substantial costs" is also variable by Indian Tribe. Each Indian Tribe and the Secretary shall mutually determine the level of costs that represent "substantial costs" in the context of the Indian Tribe's resource base.

26. **To the Extent Practicable and Permitted by Law** – Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc.

27. **Treaty** – A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.

28. **Tribal Government** – An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a.

29. **Tribal Officials** – Elected or duly appointed officials of Indian Tribes or authorized inter-Tribal organizations.

30. **Tribal Organization** – The recognized governing body of any Indian Tribe; any legally established organization of American Indians and Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the community to be served by such organization and which includes the maximum participation of Indian Tribe members in all phases of its activities (25 U.S.C. 450b).

31. **Tribal Resolution** – A formal expression of the opinion or will of an official Tribal governing body which is adopted by vote of the Tribal governing body.

32. **Tribal Self–Governance** – The governmental actions of Tribes exercising self-government and self-determination.

33. **Urban Indian Organization** – A program that is funded by the Indian Health Service under Title V (Section 502 or 513) of the Indian Health Care Improvement Act.

19. ACRONYMS

AI/AN:	American Indian/Alaska Native
AI/AN/NA:	American Indian/Alaska Native/Native American
ASBTF:	Assistant Secretary for Budget, Technology and Finance
BIA:	Bureau of Indian Affairs
Division:	Staff Division and/or Operating Division
EO:	Executive Order
FACA:	Federal Advisory Committee Act
FR:	*Federal Register*
GPRA:	Government Performance Results Act
HHS:	U.S. Department of Health and Human Services
ICNAA:	Intradepartmental Council on Native American Affairs
IGA:	Office of Intergovernmental Affairs
IHS	Indian Health Service
IOS:	Immediate Office of the Secretary
NPRM:	Notice of Proposed Rule Making
OMB:	Office of Management and Budget
OS:	Office of the Secretary
PART:	Performance Assessment Rating Tool
TCPRW:	Tribal Consultation Policy Revision Workgroup
U.S.:	United States
U.S.C.:	United States Code

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F: Centers for Disease Control and Prevention (CDC) Tribal Consultation Advisory Committee (TCAC)

Charter

PURPOSE

The Federal delivery of health services and funding of programs to maintain and improve the health of AI/AN are consonant with and required by the Federal Government's historical and unique legal relationship with Indian Tribes, as reflected in the Constitution of the United States. In recognition of this and pursuant to Presidential Executive Order No. 13175, November 6, 2000, and the Presidential Memorandum of September 23, 2004, the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) have established a Tribal Consultation Policy for working with Federally-recognized Tribes on a government-to-government basis. The CDC Tribal Consultation Policy establishes the formation of a Tribal Consultation Advisory Committee (TCAC) to serve as an advisory body to CDC.

The purpose of the CDC TCAC is to provide a complementary venue wherein tribal representatives and CDC staff will exchange information about public health issues in Indian country, identify urgent public health needs in AI/AN communities, and discuss collaborative approaches to addressing these issues and needs. The CDC TCAC will support, and not supplant any other government-to-government consultation activities that CDC undertakes. In addition to assisting CDC in the planning and coordination of biannual tribal consultation sessions, the TCAC will provide an established, recurring venue wherein tribal leaders will advise CDC regarding the government-to-government consultation process and will help to ensure that CDC activities or policies that impact Indian country are brought to the attention of all tribal leaders. The TCAC will assist CDC in the planning and coordination of Tribal consultation sessions and help to ensure that CDC activities or policies that impact Indian country are brought to the attention of Tribal leaders.

AUTHORITY

The U.S. Department of Health and Human Services (HHS) has adopted a Tribal Consultation Policy that applies to all HHS Divisions and includes CDC. The HHS Tribal Consultation Policy directs Divisions to establish a process to ensure accountable, meaningful, and timely input by Tribal officials in the development of policies that have Tribal implications. The President also signed an Executive Memorandum entitled "Government-to-Government Relationship with Tribal Governments", reaffirming this government-to-government relationship with Indian Tribes on September 23, 2004. In response to these directives, CDC developed a Tribal Consultation Policy that establishes the TCAC.

The TCAC charter complies with the statutory provisions set forth at 2 U.S.C. § 1534(b)1(1) & (2), and therefore will not implicate the Federal Advisory Committee Act (FACA). The method

[1] *2 U.S.C. § 1534 (b) provides: The Federal Advisory Committee Act (5 U.S.C. app.) shall not apply to actions in support of intergovernmental communications where –* (1) *meetings are held exclusively between Federal official and elected officers of State, local and Tribal governments (or their designated employees with authority to act on their behalf) acting in their official capacities; and* (2) *such meetings are solely for the purposes of exchanging*

for selecting Tribal members of the TCAC is designed to acknowledge the role of Tribal governments and their elected or appointed officials with regard to consultation on policy issues.

FUNCTION

The TCAC will provide a forum for meetings between Federal officials and elected or appointed Tribal leaders (or their designated employees with authority to act on their behalf); as well as representatives of national Tribal organizations designated by Tribal leaders to act on their behalf, in compliance with the exemptions with FACA. These programs may be funded in whole or in part by CDC. The meetings will facilitate the exchange of views, information, or advice concerning the intergovernmental responsibilities in the implementation and/or administration of CDC programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. Such meetings include, but are not limited to, seeking consensus, exchanging views, information, advice, and/or recommendations, or facilitating any other interaction relating to intergovernmental responsibilities or administration. Meetings may be face-to-face or via conference call. TCAC meetings will complement and not supplant the Tribal consultation process between CDC and the Tribes.

STRUCTURE

The TCAC will be composed of 16 members (and designated alternates) who are either elected or appointed officials of Tribal Governments (or tribal employees who are designated to act on their behalf), or representatives from national tribal organizations designated by Tribal leaders to act on their behalf.

TCAC membership will include representation from each of 12 geographic areas served by the Indian Health Service (IHS). These Areas include the following: Alaska Area, Albuquerque Area, Aberdeen Area, Billings Area, Bemidji Area, California Area, Nashville Area, Navajo Area, Oklahoma Area, Phoenix Area, Portland Area, and Tucson Area.

In addition, the TCAC will include one representative (and designate alternates) from 4 national tribal organizations: the National Indian Health Board (NIHB), National Congress of American Indians (NCAI), Tribal Self-Governance Advisory Committee (TSGAC), and Direct Service Tribes Advisory Committee (DSTAC).

The designated alternate may participate in the TCAC meetings on behalf of the principle member when that member cannot attend. If that designated alternative is not available, the principle member shall designate a second alternate in writing prior to the TCAC meeting.

CDC SUPPORT

The Office of the Director, CDC, through the Office of Minority Health and Health Disparities (OMHD), Office of Strategy and Innovation, will be responsible for ensuring agency-wide adherence to CDC and HHS tribal consultation policies. The TCAC Executive Secretary will be designated by OMHD. The Executive Secretary and the CDC Senior Tribal Liaisons will support TCAC functions and serve as scientific and programmatic resources for the TCAC.

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views, information, or advice relating to the management or implementation of Federal programs established pursuant to public law that explicitly or inherently share intergovernmental responsibilities or administration.

In addition, key CDC managers and staff with programmatic expertise, as determined by the CDC Director, shall serve as resources to the TCAC by providing leadership, technical assistance, and subject matter expertise to the TCAC in carrying out its duties and responsibilities. As part of these responsibilities, CDC staff will monitor Tribal access to CDC and ATSDR programs by tracking the total resources allocated annually to serve AI/ANs, and prepare an inventory of new programs and policies affecting AI/AN communities.

Because the TCAC is a high level agency advisory committee, it should be understood that the Director and her/his immediate staff as well as Coordinating Center Directors and Directors of Centers, Institutes, and Offices should prioritize and attend the TCAC meetings so that the TCAC can fulfill its purpose. In addition to the executive leadership of the agency, other CDC staff with particular programmatic and technical expertise should be available and responsive to issues and inquiries to allow the TCAC to achieve their role and responsibilities realized through an established trust relationship with CDC and ATSDR.

NIHB SUPPORT

In keeping with the responsibilities outlined in its Cooperative Agreement with the CDC/ATSDR, NIHB will provide a broad spectrum of services for the support, implementation and advancement of the TCAC. Some of these responsibilities include; maintaining a TCAC charter list; assisting the TCAC and CDC in the solicitation of AI/AN Tribal Leader input on public health issues and disseminate information to Indian country (via Tribal Leader letters, website notices, etc); develop meeting agendas and compile briefing booklets/materials for meetings; document principal discussions and recommendations from TCAC meetings. NIHB also will provide policy, outreach and communication services to and on behalf of TCAC to the Tribes and CDC. Further, NIHB will support the TCAC with its preparation of testimony and comments during the budget consultation process. (These functions are in addition to the logistical operations and meeting planning services discussed later in this document). The Director of Public Health Programs and Outreach: This National Indian Health Board (NIHB) position will serve as the technical support for policy, outreach and communication to the TCAC.

APPOINTMENT PROCESS

The Area Health Boards or Area Tribal Consortia, or Area Tribal Caucus (hereinafter referred to as the appointing body) may choose how their TCAC representatives are selected from each Area but should institute clear procedures as to how these representatives will keep their constituents informed of TCAC activities. The NIHB staff will work with the Tribal Leaders and the Area Health Boards and CDC to ensure that representatives from each of the Areas and national Tribal organizations are designated. The CDC Senior Tribal Liaison for Policy and Evaluation is responsible for ensuring the representatives (and alternates) meet the Federal Advisory Committee Act (FACA) exempt requirements for representation. The NIHB will maintain a chart listing the names and contact information of each representative (and alternate), attached as an addendum to this Charter.

LEADERSHIP

Chair: A Chair will be elected by and from among the TCAC members for a one calendar-year term of service. The Chair will be an elected Tribal leader. The number of terms is not limited.

Co-Chair: The Co-Chair will be elected by and from among the TCAC members for a one calendar-year term of service. The Co-Chair will be an elected Tribal leader. The number of terms is not limited.

Executive Secretary: The Executive Secretary will provide administrative support and will be designated by the CDC Office of Minority Health and Health Disparities (OMHD).

Re-election: The Chair and Co-Chair may be reelected by the TCAC.

PERIOD OF SERVICE

There is no limit to the length of service on the TCAC. The appointing group may remove or change their representative at any time.

Vacancy: When a vacancy occurs, Tribal and national Tribal organizations will be notified of the vacancy by the Chairman of the TCAC and the affected Area or the national Tribal organization will be asked to work with their respective Tribal Leadership and Area Health Board or Area Caucus to select another representative. Tribal leaders, Area Health Boards or Area Caucus' will notify CDC and the NIHB staff in writing as to the name and contact information of the new appointee. In the event of a vacancy, the alternate will attend meetings until such a time as the vacancy is officially filled.

Removal: If a designated representative does not participate in a meeting or teleconference on three successive occasions, the appointing body will be notified by the Chairman of the TCAC and requested to replace their representative with one who is able to participate regularly.

MEETINGS

Depending on availability of funds, the TCAC will convene four (4) face-to-face meetings on a fiscal year basis. Two of these face-to-face meetings will be held in conjunction with formal CDC tribal consultation sessions twice each year. Each year, CDC will invite all elected tribal leaders, or their designees, to attend the two CDC tribal consultation sessions; one in Atlanta hosted by CDC and one in a second location hosted by an Area Health Board or the National Indian Health Board. The TCAC will assist in the planning and coordination of each consultation session. TCAC conference calls will be held as needed and additional meetings may be scheduled depending on need and availability of funds.

VOTING

The TCAC will operate by consensus and where a consensus cannot be reached, then the TCAC will vote to resolve any differences. Each TCAC member (primary member, alternate member or their designee) will be allowed one vote.

QUORUM

A quorum is established with a majority of voting members present (9 of 16). In the event TCAC is not able to establish a quorum for its meeting, then in the alternative, the co-chairs in their discretion can arrange for polling of members via conference call or other manner.

COMPENSATION

Members who are not Federal employees shall be paid a rate of $250 per meeting, plus per diem, and travel expenses in accordance with Standard Government Travel Regulations (e.g., two week minimum advance airline reservations, unless prior approval.) Attendance is necessary to receive this benefit.

REPORTS

NIHB will assure that all TCAC meeting proceedings and recommendations are formally recorded and provided to TCAC primary and alternate members, and the CDC Executive Secretary through written minutes provided within 15-days following the TCAC meeting. Once approved, they also will be posted on NIHB's website so that the information is accessible to all AI/AN Tribal Governments. Meeting summaries will be made available within 15-days following the TCAC meeting.

The Executive Secretary will ensure that all TCAC meetings and recommended actions are made available to CDC leaders and will post minutes and reports on the CDC website within 15 days following the TCAC meeting.

Recommended follow-up actions requiring federal actions and/or attention will be implemented and tracked within CDC and reported to TCAC in a timely manner.

MEETING LOGISTICS:

The NIHB, working with CDC and TCAC Chair and Co-Chair, will arrange meeting logistics. This includes coordinating hotel and airline travel arrangements for TCAC members, audio/visual coordination, providing travel reimbursements and applicable honoraria to TCAC members.

The CDC will provide onsite meeting coordination for the annual TCAC meeting and consultation meetings that take place at CDC in Atlanta, Georgia.

TCAC BUDGET

On an annual basis, NIHB will work with TCAC to develop the TCAC budget, including travel, per diem, communication, printing, personnel and other related expenses. This proposal will be provided to CDC/ATSDR on an annual basis for each subsequent fiscal year.

MEANINGFUL ACCESS

As stated in the "CDC Support" section, a portion of the agenda for each TCAC meeting will include time with CDC/ATSDR leadership. This will ensure that the input and recommendations provided by Tribal leaders will impact CDC decision-making processes and help guide CDC as it strives to protect people's health and safety, provide reliable health information, and improve health through strong partnerships. CDC OMHD will track the progress of recommendations and follow-up actions and report to TCAC primary and alternate members during subsequent meetings.

TERMINATION DATE

This TCAC Charter shall be effective as long as the CDC Tribal Consultation Policy is in effect.

Glossary of Terms:

CDC	Centers for Disease Control and Prevention
ATSDR	Agency for Toxic Substance and Disease Registry
OMHD	Office of Minority Health and Health Disparities
OSI	Office of Strategy and Innovation
COTPER	Coordinating Office for Terrorism Preparedness and Emergency Response
NIHB	National Indian Health Board
TCAC	Tribal Consultation Advisory Committee
FACA	Federal Advisory Committee Act
AI/AN	American Indian/Alaska Native

G: CDC TCAC Members

Area Office	Principal Member	Alternate 1
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H: American Indian/Alaska Native Health Research Advisory Council

PURPOSE

Many organizational components of the Department of Health and Human Services (HHS) support research on the health needs of American Indians and Alaska Natives (AI/AN) but to date, there have been few formal avenues through which the Department gathers tribal input on the research needs and priorities of tribes. While the Department and its divisions and staff divisions (OPDIVS/STAFFDIVS) have tribal consultation policies in place, regularly scheduled consultation meetings tend to focus on more immediate service delivery and financing issues. AI/AN research priorities do not receive regular or in-depth consideration at most consultations. Moreover, none of the Departmental components have AI/AN groups to provide advice specifically on health research matters. In addition, no active organization within the Department is charged with coordinating and optimizing AI/AN health research.

It would not be efficient for each affected operating and staff division (OPDIV /STAFFDIV) to conduct its own health research consultations with AI/AN leaders and groups. For each relevant departmental component, a separate consultation with tribal leaders would mean fielding the costs of establishing the groups, traveling to periodic meetings, distribution of relevant materials to members, etc. For AI/AN representatives, it would mean being asked repeatedly to identify their health research priorities; with perhaps only minor changes each time (specific to the mission of each OPDIV/STAFFDIV). This entails a great deal of time and effort on the part of the AI/AN representatives, including time used to travel to and participate in multiple meetings.

This initiative establishes a group of tribal leaders to provide input on the health research priorities and needs of AI/ANs. The Group would serve three distinct but interrelated functions:

1) Obtain input from tribal leaders on health research priorities and needs for their communities; based on this input assist the Tribes with the development of an HHS wide AI/AN priority research agenda.

2) Provide a forum through which OPDIV and STAFFDIV representatives can better communicate and coordinate the work their respective organizations are doing in AI/AN health research; and

3) Provide a conduit for disseminating information to tribes about research findings from studies focusing on the health of AI/AN populations.

Input provided by the tribal representatives will be used as an important source of information in the developing and coordinating of OPDIV/STAFFDIV research portfolios. Information collected by this group will be in accordance with the Secretary's Tribal Consultation Policy that was signed on January 14, 2005. It will be used as a resource to complement other avenues of input, such as disease specific advisory groups that are currently active in certain agencies of the Department.

Representatives from several HHS components will participate in the AI/AN Health Research Council including: the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Office of Intergovernmental Affairs (IGA), the Agency for Healthcare Research and Quality (AHRQ), the Indian Health Service (IHS), the National Institutes of Health (NIH), the Secretary's Office of Minority Health (OMH)/Office of the Secretary, and the Centers for Disease Control (CDC). The Office of Minority Health will provide leadership and coordination support to the Council.

BACKGROUND INFORMATION

A unique government-to-government relationship exists between American Indian and Alaska Native (AI/AN) Tribal Governments and the Federal government. Treaties and laws, together with court decisions, have defined a relationship between Tribal Governments and the Federal government that is unlike that between the Federal government and any other group of Americans. Since the formation of the Union, the United States has recognized Tribal Governments as sovereign nations. The Federal Government has enacted numerous regulations that establish and define a trust relationship with Tribal Governments. The government-to-government relationship between the United States and Tribal Governments dictates that the principal focus for HHS consultation is with individual Tribal Governments.

An integral element of this government-to-government relationship is that consultation occur with Tribal Governments on issues that impact them, and that Tribal Governments participate in the decision making process to the greatest extent possible. This relationship with Tribes was reaffirmed on September 23, 2004 by Executive Memorandum entitled "Government-to-Government Relationship with Tribal Governments." The implementation of this policy is in recognition of this special relationship and in accordance with the Department's Tribal Consultation Policy.

The requirements are contained in statutes and various Presidential executive orders including:

- Older Americans Act, P.L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, P. L. 93-638, as amended;
- Native Americans Programs Act, P.L. 93-644, as amended;
- Indian Health Care Improvement Act, P. L. 94-437, as amended;
- Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994;
- Presidential Executive Order 13084, Consultation and Coordination with Indian Tribal Governments, May 14, 1998
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000; and
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004

FEDERAL ADVISORY COMMITTEE ACT (FACA)

The group under consideration would be a form of advisory group. FACA (Pub. L. 92-463, 5 U.S.C. App.) establishes rules governing the establishment, management, and termination of advisory groups of all kinds. That law requires that advisory groups meet certain structural and procedural requirements and be authorized in legislation, by the President, or by the head of a Federal Department with the approval of the Administrator of GSA.

> The proposed advisory group qualifies for an exemption under FACA. The exemption states that federal agencies' consultations with AI/AN tribes are exempted from FACA as a form of intergovernmental consultation through which tribal governments provide timely input to federal agencies regarding the implementation of public laws requiring shared responsibilities or administration. This exemption is specific to the elected officers and their designated employees (with authority to act on their behalf) of tribal governments, as well as the Washington representatives of AI/AN tribes. And, according to guidelines published in the Federal Register, the exemption from the FACA rules for intergovernmental consultation "should be read broadly to facilitate intergovernmental communications on responsibilities or administration." Relatedly, the guidance goes on to state that "[T]he scope of meetings covered by the exemption should be construed broadly to include any meetings called for any purpose relating to intergovernmental responsibilities or administration. Such meetings include, but are not limited to, seeking consensus, exchanging views, information, advice, and/or recommendations; or facilitating any other interaction relating to intergovernmental responsibilities or administration."
> 60 Fed. Reg. 50,653.

STRUCTURE

The formation of the AI/AN Health Research Advisory Council is responsive to tribal leaders' recommendations at HHS consultation sessions. OMH will develop a solicitation process for the selection of Tribal representative to this group. The group will consist of the following:

> Representing Tribes: Elected tribal officials (12-15 persons)
> One Tribal representative and one alternate from each of the 12 IHS Areas and one representative from the Washington based Tribal Organizations that represent Tribes.
>
> Representing Operating and Staff Divisions of the Department: A senior staff member from each participating division having knowledge of, and the potential to engage, in research on AI/AN health.

The tribal participants would be elected tribal officials from federally recognized tribes in each IHS area. A letter will be sent out to every tribal leader soliciting nominations for this group. Every area will have the flexibility to determine who from their area will represent them. We recognize that every area conducts this selection process differently. In the event that we receive more then one name from an area the Director of OMH will consult with the participating HHS components in the selection process of Tribal representatives.

PROCESS

The Department plans to convene the council at least annually in the Washington, D.C. area, with interim conference calls as needed. Representatives from each OPDIV/STAFFDIV will attend the annual meeting of the group. After the formal session, a summary of tribal recommendations will be developed. Representatives of the OPDIVs/STAFFDIVs will bring this summary back to their home organizations for use in strategic plan and budget development, as well as for discussions with the representatives of other departmental organizations about how they might work together to accomplish some of the stated priority research needs of the tribal group. The representatives of the OPDIVs/STAFFDIVs will meet formally at least once per year, shortly after the annual group meeting, to discuss the identified priorities and possible collaborations.

COMPENSATION

No compensation will be paid to tribal representatives for their participation in this group. However, travel and lodging costs for the Tribal Representatives that are selected to participate in this Council will be reimbursed via funding established under an interagency agreement set up to establish this research advisory group, pursuant to applicable Federal travel regulations.

REPORTS

To promote widespread dissemination of the tribal priorities and recommendations and identify current departmental research on AI/AN health, an annual report will be prepared. The report will include a summary of tribal priorities identified at the annual meeting as well as research undertaken by the department during the past year focused on AI/AN health issues and any newly released findings resulting from any previous studies specifically examining AI/AN health issues. This report would be distributed throughout the Department and to all federally recognized tribes.

CONTRIBUTIONS AND RESPONSIBILITIES OF THE PARTICIPATING OPDIVs/STAFFDIVs

The participating OPDIVs and STAFFDIVs will:

1. Participate in the annual consultation with the tribal group. A senior staff member will be present at the annual meeting with the tribal group;

2. Participate in follow-up meetings of departmental senior staff to discuss tribal research priorities and possible collaborations;

3. Use the information supplied by the AI/AN Health Group as one form of input in the process of developing their organization's research plans with respect to AI/AN health research; and

4. Provide information to tribes and others on the outcomes of research conducted in Indian country.

ANNUAL COST ESTIMATE

The estimated annual cost is approximately $100,600 for this initiative. The majority of the budget is for travel and for the annual report.

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J: October 4, 2006 - HHS Awards $1.2 Million to Address Methamphetamine Abuse in Native American Communities

HHS Assistant Secretary for Health John Agwunobi today announced the award of $1,175,100 in funds to the American Association of Indian Physicians (AAIP) and its partners to address the outreach and education needs of Native American communities on methamphetamine (meth) abuse.

"American Indians and Alaska Natives suffer health disparities for many diseases at a higher percentage than other U.S. populations," Dr. Agwunobi said. "Tribal officials have identified meth use as one of their highest priority health issues, and called for federal and state assistance to conduct outreach and education and help reduce the toll that methamphetamine abuse is taking on their communities."

According to the National Survey on Drug Use and Health 2005, recently released by HHS, nearly 1.7 percent of the Native population has used methamphetamine, compared to less than one percent of whites, Hispanics, Asians or blacks. Methamphetamine use has been implicated in crimes against people and property, elevated suicide rates, heightened risks of hepatitis C and HIV/AIDS, needs for more foster care placements for children of users, and environmental impacts from manufacturing facilities.

This initiative identifies a two-pronged approach, including a national education and information outreach campaign and a series of knowledge transfer activities that would help communities understand promising practices in combating methamphetamine abuse. It brings federal, tribal, state, and local resources together to reach urban and rural Native American communities and families.

As part of the initiative, the partners will develop the national information and outreach campaign and a culturally specific methamphetamine abuse education kit, document and evaluate promising practices in education on meth use, and create meth awareness multi-disciplinary education teams.

The AAIP, of Oklahoma City, OK, will partner with:

- **Oregon Health and Science University-One Sky Center, Portland, OR. (OHSU-OSC).** OHSU-OSC will serve as the principal expert for behavioral health, mental health and substance abuse regarding methamphetamine abuse.
- **National Congress of American Indians, Washington, DC.** NCAI will work to provide technical assistance on a national tribal scale.
- **United South and Eastern Tribes (USET), Nashville, TN.** USET will contribute regional expertise and will track data and trends within its region.
- **Northwest Portland Area Indian Health Board (NPAIHB), Portland OR.** NPAIHB will contribute regional expertise and will track data and trends within its region.
- **Choctaw Nation, Crow Nation, Navajo Nation, Northern Arapaho Tribe, and Winnebago Tribe.** The five Tribes will provide technical assistance and document promising practices undertaken by their communities.

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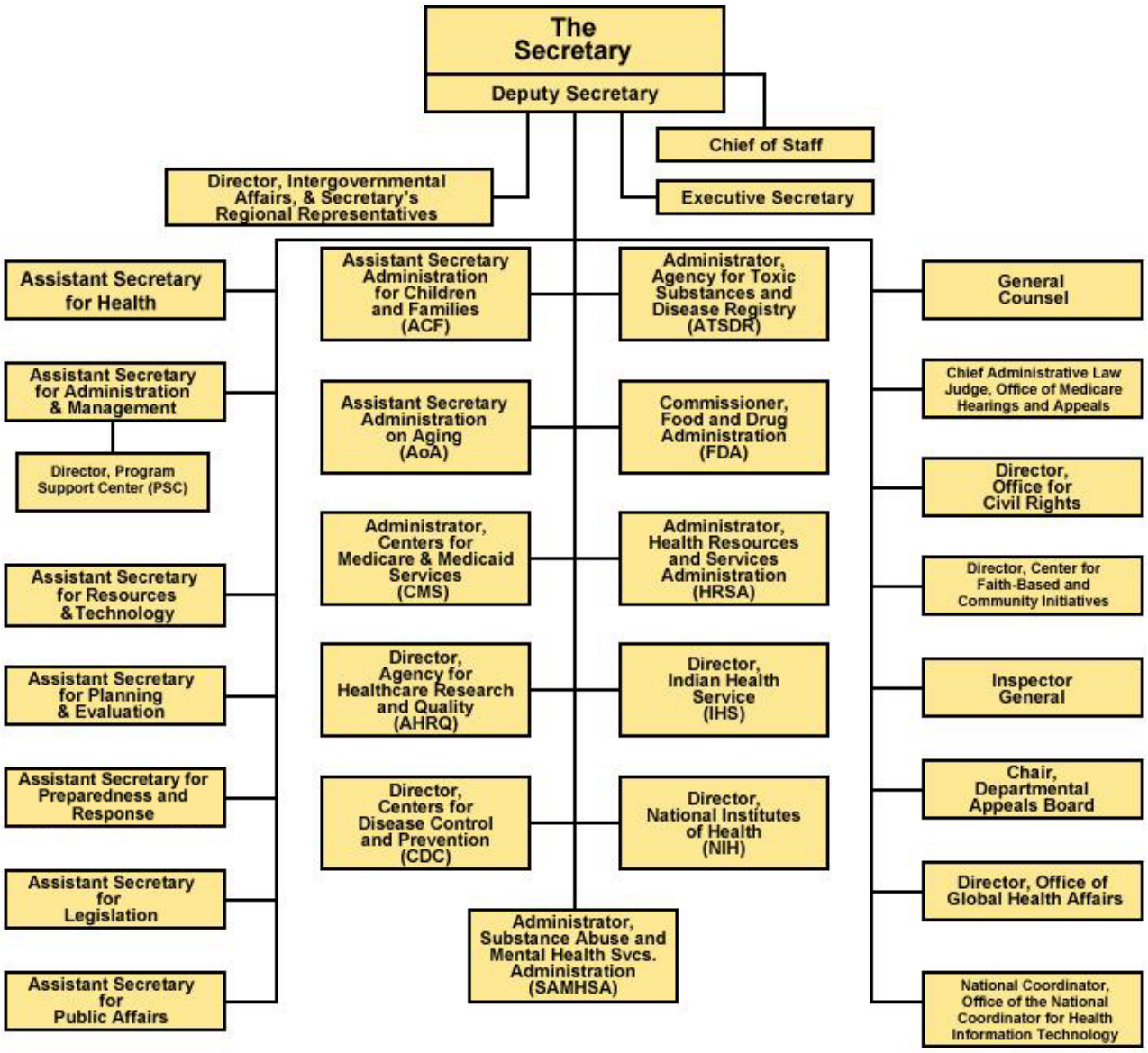
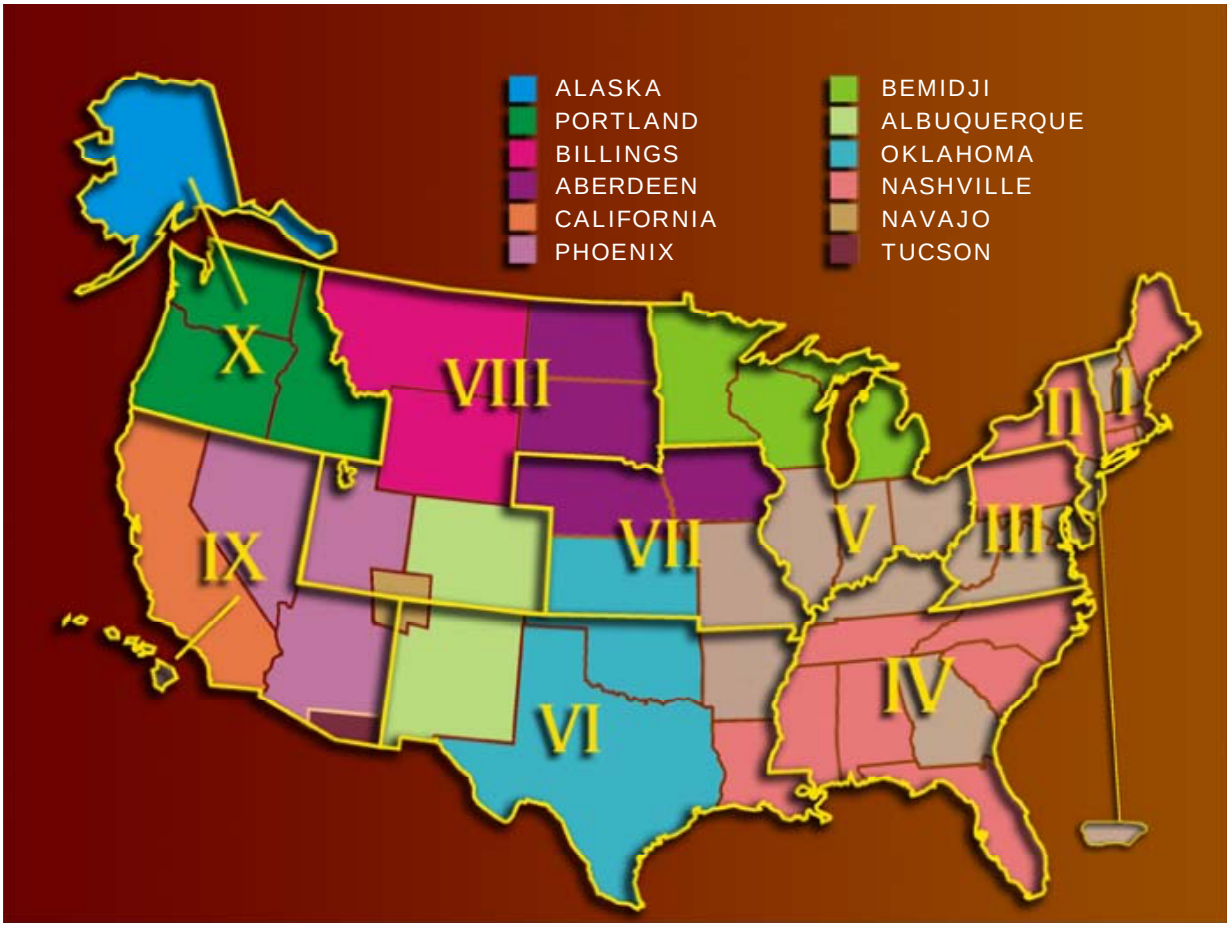
K: HHS Organization Chart



L: Indian Health Service Areas Map



ACRONYMS

ATNW	Affiliated Tribes of the Northwest
ACF	Administration for Children and Families
ACYF	Administration on Children, Youth and Families (ACF)
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian and Alaska Native
AI/AN/NA	American Indian and Alaska Native and Native American
AIHEC	American Indian Higher Education Consortium
AIP	Arctic Investigations Program
ANA	Administration for Native Americans (ACF)
ANHB	Alaska Native Health Board
AoA	Administration on Aging
APHSA	American Public Human Services Association
ASAM	Assistant Secretary for Administration and Management
ASRT	Office of the Assistant Secretary for Resources and Technology
ASH	Assistant Secretary for Health (heads OPHS)
ASL or "L"	Office of the Assistant Secretary for Legislation
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE or "P&E"	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
BHPr	Bureau of Health Professions
BIA	Bureau of Indian Affairs
BPHC	Bureau of Primary Health Care (HRSA)
CAPTs	Centers for the Application of Prevention Technologies
CB	Children's Bureau (ACF)
CCB	Child Care Bureau (ACF)
CCDF	Child Care and Development Fund
CDC	Centers for Disease Control and Prevention
CERT	Community Emergency Response Team

CFSP	Child and Family Service Plans
CFSR	Child and Family Service Review
CHC	Community Health Center(s)
CHR	Community Health Representative
CHS	Contract Health Services
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
COTPER	Coordinating Office of Terrorism Preparedness and Emergency Response
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSBG	Community Services Block Grant
CSC	Contract Support Cost
CSE	Child Support Enforcement
CVD	Cardiovascular Disease
Department	Department of Health and Human Services
DHAP	Division of HIV/AIDS Prevention (CDC)
DME	Durable Medical Equipment
DEMERC	Durable Medical Equipment Regional Carriers
DRH	Division of Reproductive Health (CDC)
DS	Deputy Secretary
DST	Direct Services Tribes
DSTDP	Division of STD Prevention
DTLL	Dear Tribal Leader Letter
EARDA	Extramural Associates Research Development Award (NIH)
ELP	Emerging Leader Program
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EO	Executive Officer
EPA	Environmental Protection Agency
ES	Executive Secretary to the Department
EWIDS	Early Warning Infectious Disease Surveillance

FAAB	Facilities Appropriation Advisory Board
FACA	Federal Advisory Committee Act
FAP	Federal Advisory Panel
FAS	Fetal Alcohol Syndrome
FBCS	Faith Based and Community Services
FDA	Food and Drug Administration
FIC	Fogarty International Center (NIH)
FMAP	Federal Medical Assistance Percentage
FOH	Federal Occupational Health
FQHC	Federally Qualified Health Center
FN	First Nations
FR	Federal Register
FSS	Federal Supply Schedule
FY	Fiscal Year
FYSB	Family and Youth Services Bureau (ACF)
GPRA	Government Performance Results Act
GSGS	Good Start, Grow Smart initiative
HCUP	Health Care Utilization Project
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPSA	Health Professions Shortage Area
HRSA	Health Resources and Services Administration
IAA	Interagency Agreement
ICNAA	Intradepartmental Council on Native American Affairs
ICs	Institutes and Centers at NIH
ICWA	Indian Child Welfare Act
IGA	Office of Intergovernmental Affairs
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
INSP	National Institute of Salud Pu'blica

IOS	Immediate Office of the Secretary
IPY	International Polar Year
ISDEAA	Indian Self Determination and Education Assistance Act
I/T/U	Indian Health Service, Tribal, and Urban Indian
LIHEAP	Low Income Home Energy Assistance Program
MAM	Medicaid Administrative Matching
MCH	Division of Maternal-Child Health
MFP	Minority Fellowship Program
MMA	Medicare Modernization Act, a.k.a. Prescription Drug Plan, Medicare Part D
NARCH	Native American Research Centers for Health
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCAI	National Congress of American Indians
NCCCP	National Comprehensive Cancer Control Program
NCHSTP	National Center for HN, STD, and TB Prevention
NCSD	National Coalition of STD Directors
NCVHS	National Committee on Vital and Health Statistics
NDEP	National Diabetes Education Program
NDWP	National Diabetes Wellness Program
NEW	Native Employment Works
NGO	Non-Governmental Organization
NHAP	National HIV/AIDS Partnership
NHDR	National Healthcare Disparities Report
NHIS	National Health Interview Survey
NHQR	National Healthcare Quality Report
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NICCA	National Indian Child Care Association
NICOA	National Indian Council on Aging
NICWA	National Indian Child Welfare Association
NIH	National Institutes of Health
NIHB	National Indian Health Board

NIMH	National Institute of Mental Health
NIP	National Immunization Program
NP AIHB	Northwest Portland Area Indian Health Board
NPRM	Notice of Proposed Rule Making
NUI	Nevada Urban Indians, Inc.
OA	Office of the Administrator
OCR	Office for Civil Rights
OCS	Office of Community Services
OCSE	Office of Child Support Enforcement
OFA	Office of Family Assistance
OFRD	Office of Force Readiness and Deployment
OGC or "GC"	Office of General Counsel
OMB	Office of Management and Budget
OMH	Office of Minority Health
OPHS	Office of Public Health and Science
ORD	Office of the Regional Director
ORHA	Office of the Regional Health Administrator
OS	Office of the Secretary
PART	Program Effectiveness Rating Tool
PMF	Presidential Management Fellow
PSA	Public Service Announcement
RH	Reproductive Health
RMHC	Regional Minority Health Coordinator
RPMS	Resource and Patient Management System
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Severe Emotional Disturbance
SERG	SAMHSA Emergency Response Grant
SHIP	State Health Insurance Program
SSA	Social Security Administration
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Diseases

TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TCE	Targeted Capacity Expansion Program
TCP	Tribal Consultation Policy
TCPRW	Tribal Consultation Policy Revision Workgroup
TCU	Tribal Colleges and Universities
TEHEP	Tribal Environmental Health Education Program
TriTac	Tribal Child Care Technical Assistance Center
TLDC	Tribal Leaders Diabetes Committee
TSGAC	Tribal Self-Governance Advisory Committee
TTAG	Tribal Technical Advisory Group (CMS)
USDA	U.S. Department of Agriculture
USET	United South and Eastern Tribes, Inc.
VA VFC	Veterans Administration Vaccine for Children
WINS	Washington Internships for Native Students